

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01200

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH: Allegany
 County.....
Cumberland, Md.
 City or town.....
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 yrs
 Hospital, institution, or street address where death occurred:
416 Franklin Street
 Now long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town.....
Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 416 Franklin St
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Margaret Arsilvia Abe

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
Isaac F Abe
 6.(b) Name of husband or wife.....
 6.(c) If alive, give age 77 years
 7. Birth date of deceased (mo., day, yr.) June 24, 1866
 8. AGE: Years 81 Months 7 Days 24 If less than one day
hrs. min.

9. Birthplace.....
Little G. W. Va.
 (Town, county, and state)
House Wife

10. Usual occupation.....
 11. Industry or business.....

MOTHER FATHER
 12. Name Frederick L Kerns
 13. Birthplace Virginia
 14. Maiden name Mary E Hartley
 15. Birthplace Flintstone, Md.

16. Informant.....
 Address Barrie Kerns 416 Franklin

17. Burial, cremation, or removal. Which? Burial Date thereof Feb. 20, 1948
 (month) (day) (year)

Cemetery or crematory.....
Bethel Cemetery
Paw Paw W. Va.
 Location.....

18. Funeral director.....
John B. McFarland
 Address 125 S Liberty St.

19. Feb. 19 1948 Walter P. Prantz
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 18 19 48 at 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
about Jan 1 19 35 to Feb 18 19 48
 and that I last saw him alive on Feb 18 19 48

Immediate cause of death..... DURATION
Chr myocarditis?
 Due to Arterio sclerosis?
 Due to Hemiplegia 12 hrs
 Other conditions.....
 (Include pregnancy within 3 months of death)

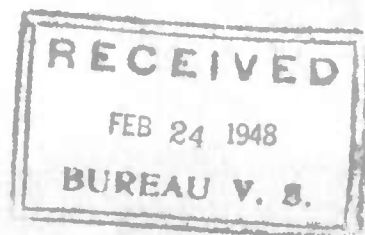
Major findings of operations..... Date of op.

Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
 Means of injury..... Injured at work?

23. SIGNATURE L. M. Wilson M. D. or other
 Address Cumberland Md signed 2-18-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

01201

DR. RICHARD WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State WEST VIRGINIA County MorganCity or town PAW PAW
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

MR. LLOYD AMBROSE

3. (b) Social Security Number

4. Sex

MALE

5. Color or race

WHITE

6.(a) Single, married, widowed, or divorced

MARRIED6.(b) Name of husband or wife ROSIE WAGNER7. Birth date of deceased (mo., day, yr.) OCTOBER 28, 18938. (c) If alive, give age 53 years8. AGE: Years 54 Months 4 Days 15 If less than one day
hrs. min.9. Birthplace WEST VIRGINIA
(Town, county, and state)10. Usual occupation KEYSTONE TANNERY AND GLUE CO.11. Industry or business PAW PAW, W. VA.12. Name MR. GEORGE AMBROSE (Deceased)13. Birthplace WEST VIRGINIA14. Maiden name MOLLY KING (Deceased)15. Birthplace WEST VIRGINIA16. Informant Mrs Rosie AmbroseAddress Paw Paw, W. Va.17. Burial Date thereof 2/26/48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Woodland BurialLocation Paw Paw, W. Va.18. Funeral director H. D. ParksAddress Berkeley Springs W. Va.19. Feb. 25 1948 W. R. Kautz, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 23 19 48 at 5:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1/25/48 19 48 to 2/23/48 19 48and that I last saw him alive on 2/23/48 19 48

Immediate cause of death

UremiaDue to Chr Nephritis

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

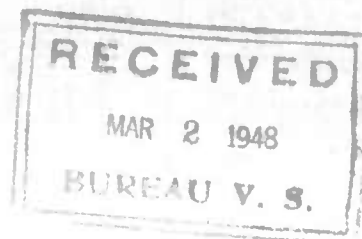
Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE _____ M. D. or other _____

Address _____ Date signed 2/23/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

Dr Reeves 01202

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
City or town Barton
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yearsHospital, institution, or street address where death occurred:
N Eutaw StreetHow long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Barton
(If outside city or town limits, write RURAL and give nearest town)Street No. N Eutaw St
(If rural, give LOCATION)2. (a) If veteran, name war - - - - -

3. (a) FULL NAME

HENRY FRANCIS BARTHALOW

3. (b) Social Security Number

* * * * *

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Anna Louise WarnickBarthallow 6. (c) If alive, give age - - - years7. Birth date of deceased (mo., day, yr.) October 16, 18698. AGE: Years 78 Months 4 Days 9 If less than one day - - - hrs. - - - min.9. Birthplace Pennsylvania
(Town, county, and state)10. Usual occupation Miner (retired)11. Industry or business Coal Mine12. Name Unknown13. Birthplace unknown14. Maiden name unknown15. Birthplace unknown16. Informant Mrs Margaret DavisAddress Barton, Maryland17. Burial Date thereof Feb 28, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Laurel Hill CemeteryLocation Moscow, Maryland18. Funeral director Ellsworth S. BoalAddress Westernport, Maryland19. Feb. 26 19 48 Ellsworth S. Boal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 19 48 at 11:30 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 21 19 48 to 2/25 19 48and that I last saw him alive on 2/25/48 19 48Immediate cause of death Chf. Cardiac vascularrenal failureDue to - - - - - DURATION PDue to - - - - -Other conditions - - - - -

(Include pregnancy within 3 months of death)

Major findings of operations - - - - - Date of op. - - - - -Autopsy results - - - - -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - - - - - Date of - - - - -Where did injury occur? - - - - - (City or town) (County) (State)Injured at home, farm, industry, public place (where?) - - - - -Means of injury - - - - - Injured at work? - - - - -23. SIGNATURE Dr. Reeves M. D. or other - - - - -Address Westernport Md Date signed 2/26/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 28 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

01203

1. PLACE OF DEATH:

County Allegany
 City or town Monacaoning
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death 14 years
 Hospital, institution, or street address where death occurred: Robbins Street
 How long in hospital or institution? 1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Monacaoning
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Robbins St
 (If rural, give LOCATION)
 2.(a) If veteran, name war 1

3. (a) FULL NAME

Mrs. Isabel Skiland Bell

3. (b) Social Security Number

1

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife John H. Bell
 6.(c) If alive, give age 73 years

7. Date of death (mo., day, yr.) June 14, 1948
 8. AGE: Years 78 Months 8 Days 0 If less than one day hrs. min.

9. Birthplace Monacaoning, Allegany Co., Md.
 (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own home

12. Name Cyrus Skiland
 13. Birthplace Pennsylvania

14. Maiden name Gray

15. Birthplace Unknown

16. Informant John Bell

Address Monacaoning, Md.

17. Burial Date thereof Feb. 17, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Monacaoning, Md.

18. Funeral director Wm. Eichhorn

Address Monacaoning, Md.

19. 2/17 48 Jannet M. Boal
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 19 48 at 6:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27 to 2/4 19 48
 and that I last saw her alive on 2/4/48 19 48

Immediate cause of death Coronary Occlusion

Due to Hypertension

Due to Coronary Occlusion

Due to Hypertension

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul Eugene Dye, M.D.

Address Monacaoning, Md. Date signed 2/17/48

RECEIVED

MAR 5 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

01204

1. PLACE OF DEATH:

County Allegany
Cumberland
City or town (If outside city or town limits, write RURAL and give nearest town)How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 216 So. Lee St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Alice L. Berkard

3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Vitus W. Berkard7. Birth date of deceased (mo., day, yr.) Oct. 29, 1891 6.(c) If alive, give age _____ years8. AGE: Years 56 Months 3 Days 17 If less than one day _____ hrs. _____ min.9. Birthplace Mt. Savage Md.
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Charles E. Witt
13. Birthplace Penna.14. Maiden name Aleinda Norris
15. Birthplace Maryland16. Informant Miss. Elizabeth Berkard
Address 216 SO. Lee St. Cumberland, Md.17. Burial Date thereof Feb. 19, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory S.S. Peter & Paul
Location Cumberland, Md.18. Funeral director Charles L. George
Address Cumberland, Md.19. Feb. 19, 1948 W.H. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1948 at _____ M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1, 1948 to Feb. 16, 1948
and that I last saw him alive on Feb. 15, 1948Immediate cause of death Cerebral V. Disease - acuteDue to Chronic Alcoholism

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE B. M. Schuchter M.D.
M. D. or other _____Address 41 Date signed Feb. 17, 1948

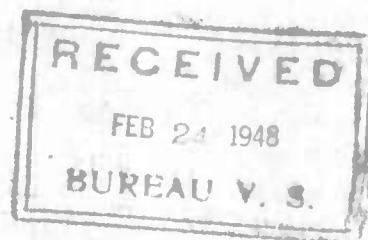
MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Outside of
City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

01205

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 Years
Hospital, institution, or street address where death occurred:
Rt 3, Bowman's Addition
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt 3, Bowman's Addn.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Charlotte Jeanette Berry

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Charles Berry

7. Birth date of deceased (mo., day, yr.) July 9 1867 6.(c) If alive, give age 80 years

8. AGE: Years 80 Months 7 Days 11 If less than one day _____ hrs. _____ min.

9. Birthplace Flintstone, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation House

11. Industry or business

12. Name Solomon Oster

13. Birthplace Flintstone Md.

14. Maiden name Percilla Elliott

15. Birthplace Centerville, Pa.

16. Informant Mrs Harry F. Miller

Address Bedford, Pa.

17. Burial Date thereof 2/23/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Dale Cemetery

Location Chaneysville, Pa.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Feb 23, 1948 W. J. Tantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 20, 1948 at 3-50 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19, 48 to Feb 20, 48
and that I last saw her alive on Feb 13, 1948

Immediate cause of death Cerebral Vascular Accident DURATION 3 wks

Due to Cerebral Atherosclerosis 4 yrs

Due to Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones, M.D. M. D. or other

Address 1102 Centre St Date signed 2-21-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1948

BUREAU V. S.

Within corporate limits

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Arthur Jones

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

93d

01206

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany County Infirmary
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 323 Baltimore Avenue
2.(c) If veteran, name war

3. (a) FULL NAME
George Richard Black

3. (b) Social Security Number
None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Stella Lindamood Black
7. Birth date of deceased (mo., day, yr.) Unknown
8. AGE: Years Approx. 85 Months Days If less than one day hrs. min.

MEDICAL CERTIFICATION
20. DATE OF DEATH Feb. 17, 1948 at 6P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to Feb 17 1948
and that I last saw him alive on Feb 17 1948

Immediate cause of death Myocardial Failure
Due to Chronic Myocarditis

DURATION
18 hrs.
4 yrs.

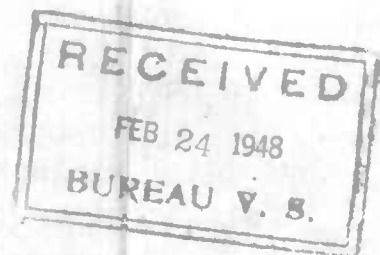
9. Birthplace Keezletown, Va.
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business Clerk
12. Name George Black
13. Birthplace Va.
14. Maiden name Unknown
15. Birthplace Unknown

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.

18. Informant Mrs. Stella Black
Address 323 Baltimore Ave. Cumberland, Md.
17. Cremation Date thereof Feb. 20, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Homewood Crematory
Location Pittsburgh, Penna.
18. Funeral director Charles L. George
Address Cumberland, Md.
19. Feb. 19 1948 W. R. Frank M.D.
(Date rec'd by registrar) Registrar

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Arthur F. Jones M.D.
M. D. or other
Address 110 S. Centre St. Date signed 2-18-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Reeves

21207

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
City or town Luke
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

307 Cromwell St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Luke
(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 Cromwell Street

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

GEORGE HENRY BOYCE

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Ida Alice BrumbackBoyce

6. (c) If alive, give age - - - years

7. Birth date of

deceased (mo., day, yr.)

August 10, 1865

8. AGE:

Years

Months

Days

If less than one day

82521

hrs.

min.

9. Birthplace Woodstock, Shenandoah, Virginia

(Town, county, and state)

10. Usual occupation Carpenter (retired)11. Industry or business West Va Pulp and Paper Co.

12. Name

John Peter Boyce

13. Birthplace

Virginia

14. Maiden name

not known

15. Birthplace

not known

16. Informant

Mr Clyde Boyce

Address

Luke, Maryland

17.

Burial

Date thereof

Feb 4, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Philos Cemetery

Location

Westernport, Maryland

18. Funeral director

Ellsworth S. Boal

Address

Westernport, Maryland

19.

(Date rec'd by registrar)

Feb 4 1948

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 1 19 48 at 9:50p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/1/48 19 48 to 2/1/48 19and that I last saw him alive on 2/1/48 19

Immediate cause of death

Branchial pneumonia

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

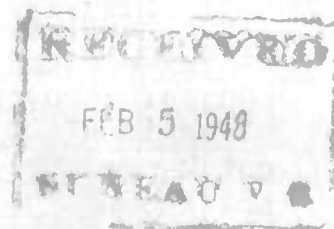
Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address Westernport, Md Date signed 2/4/48



Within corporate limits

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

97

01208

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
34 Race St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State Maryland County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 34 Race St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Frank M. Bridges

3. (b) Social Security Number
None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Etta Sommerloth

7. Birth date of deceased (mo., day, yr.) May 30 1866
8. AGE: Years 81 Months 8 Days 21 hrs. min.

9. Birthplace Beansboro Pa
(Town, county, and state)
10. Usual occupation City of Cumberland Employee
11. Industry or business Retired 9 yrs.

12. Name Frank Bridges
13. Birthplace Unknown
14. Maiden name
15. Birthplace

16. Informant Etta Bridges
Address 34 Race St. Cumberland, Md

17. Burial Date thereof Feb. 23, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hillcrest Burial Park
Location Cumberland, Md.

18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19. Feb. 23, 1948 W.R. Raatz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
20. DATE OF DEATH Feb. 21, 1948 at 12:30 A.M.

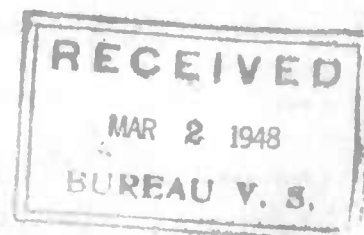
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 20, 1948 to Feb. 21, 1948
and that I last saw him alive on Feb. 20, 1948

Immediate cause of death Phaemia due to Hypertension DURATION 3 wks.
Atherosclerosis 10 yrs
Due to
Due to
Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clayton L. Jones M. D. or other
Address Cumberland Date signed 2/21/48



CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Alligany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 yrs
Hospital, institution, or street address where death occurred Alligany Hospital
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Alligany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 477 Lena St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Sophie M. Burns

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1866

8. AGE: Years 81 Months Days If less than one day hrs. min.

9. Birthplace Cumberland, Ind
(Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business

12. Name Burns

13. Birthplace unknown

14. Maiden name Anna M. Wersich

15. Birthplace Ind.

16. Informant Sam Indarian

Address Cumberland Ind.

17. Burial Date thereof 2-15-48
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory St Lukes Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Feb 14 19 48 M. H. Brady, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 19 48 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-21-48 19 48 to 2-13-48 and that I last saw h. alive on 2-12-48 19 48

Immediate cause of death

Coronary occlusion

DURATION

6 days

Due to

Due to

Other conditions Treated Rt Femur

4 wks

(Include pregnancy within 3 months of death)

Major findings of operations None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 1/21/48

Where did injury occur? Cumberland Ind.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Stumbled over step at kitchen door Injured at work? Yes
(4/6/48/48)

23. SIGNATURE GE Zimmerman M. D. or other

Address Cumberland Date signed 2-13-48

RECEIVED

FEB 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

01210

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County AlleghenyCity or town Near Cummings Park
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt 6, Narrows Park

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Anna Elizabeth Connelly

3. (b) Social Security Number

220-07-6725

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Chas. Gregory Connelly

7. Birth date of deceased (mo., day, yr.)

March 30, 1921

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

26106

hrs.

min.

9. Birthplace

Cumberland, Allegheny Co., Ind.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Iron Works

MOTHER

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Feb. 9

1948

(Date rec'd by registrar)

Date thereof: Feb 9, 1948
(month) (day) (year)Greenmount CemeteryCumberland Ind.John J. HoferCumberland Ind.Walter R. Rantz, MD
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1948 at 5:48 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1948 to 1948and that I last saw h. er alive on 6 February 1948Immediate cause of death Post Partum Hemorrhage DURATION+ ShockDue to Uterine Atony

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Atonic UterusDate of op. 6 Feb 48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Leland B. Ransom MDAddress 41 Greene St. Date signed 9 Feb 48

RECEIVED

FEB 18 1948

BUREAU V

Evidence for change of
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

Dr Giffen
Keyser

01211

FILM No. G 114 MAR 15 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: Allegany
County Westernport, rural
City or town (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years
Hospital, institution, or street address where death occurred:
2 miles south of Westernport
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Westernport, rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 miles south of Westernport
(If rural, give LOCATION)
2. (a) If veteran, name war

3. (a) FULL NAME

MARY VIRGINIA COOK

3. (b) Social Security Number

Sex female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
3. (b) Name of husband or wife Samuel A. Cook
Birth date of deceased (mo., day, yr.) September 6, 1872
AGE: Years Months Days it less than one day
75 74 5 23 hrs. min.

9. Birthplace St George, Preston, W. Va.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business Own home

12. Name John Burns

13. Birthplace

14. Maiden name Sarah Ann Davis

15. Birthplace

16. Informant Walter Cook

Address Piedmont, W. Va.

17. Burial Date thereof March 3, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Queens Point Cemetery

Location Keyser, West Virginia

18. Funeral director Ellsworth S. Boal

Address Westernport, Maryland

19. May 2, 1948 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 29, 1948 at 5:00p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945, to 2-29-48
and that I last saw him alive on 2-29-48

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed 3-1-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 4 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01212

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 hrs.
 Hospital, institution, or street address where death occurred:
Miner's Hospital
 How long in hospital or institution? 10 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegany
 City or town Eckhart
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

George Coriage
 4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Annie Couch

7. Birth date of deceased (mo., day, yr.) May 5th 1880 6.(c) If alive, give age 56 years

8. AGE: Years 67 yrs. Months 9 mo. Days 20 ds. If less than one day _____ hrs. _____ min.

9. Birthplace Yugoslavia
 (Town, county, and state)

10. Usual occupation Coal Miner

11. Industry or business

12. Name Unknown
 13. Birthplace Unknown
 14. Maiden name Unknown
 15. Birthplace Unknown

18. Informant Mrs. Minnie Wolfel
 Address Eckhart, Md.

17. Burial Date thereof Feb 27th 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Allegany
 Location Frostburg, Md.

18. Funeral director Jacob Hafer
 Address Frostburg, Md.

19. 2-27-48 Dr. Harvey H. Roe
 (Date rec'd by registrar) Registrar

3. (b) Social Security Number

213-05-9214

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 19 48 at 1:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 19 48 to Feb 25 19 48 and that I last saw him live on Feb 24 19 48

Immediate cause of death Chr. Myocarditis DURATION 2 yrs

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Wm Lane MD M. D. or other

Address Frostburg Md Date signed 2-27-48

129
1/1/48

RECEIVED
MAR 1 1948
BUREAU V. G.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

01213

93d

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

637 Maryland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 637 Maryland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

John Roy Cross

3.(b) Social Security Number

214-05-6468

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Elizabeth May Reed6.(c) If alive, give age 57 years7. Birth date of deceased (mo., day, yr.) Oct. 25, 1882

8. AGE: Years Months Days If less than one day

65312hrs.min.9. Birthplace Westernport, Md.

(Town, county, and state)

10. Usual occupation Retired11. Industry or business Hotel Fireman12. Name John Cross13. Birthplace Penna.14. Maiden name Amanda Miller15. Birthplace Westernport, Md.16. Informant Mrs. Elizabeth CrossAddress 637 Maryland Ave. Cumberland, Md.17. Burial Date thereof Feb. 10, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Philos Cem.Location Westernport, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Feb. 10 19 48 Walter R. Prarty

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 19 48 at 11:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

15 Dec 48 19 48 fo 22 Jan 48and that I last saw him alive on 22 Jan 48 19 48

Immediate cause of death

Hypertensive Heart Diseasewith arrhythmia & fibrillation

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. Alfred Van Oene

M. D. or other

Address Cum. Md. Date signed 9 Feb 48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V. S.

Evidence for additional information is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1370

01214

4

FILE No. G 11 MAR 8 1948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Sylvan Retreat

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. Sylvan Retreat

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Frank Bailey

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

? Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

1871 - Feb. 8.

6. (c) If alive, give age

years

8. AGE:

Years

Months

Days

If less than one day

77

hrs.

min.

9. Birthplace

Md.

(Town, county, and state)

10. Usual occupation

Cigar maker

11. Industry or business

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 23, 1948
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

W. K. Krantz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 19 1948 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1946 to Feb 19 1948and that I last saw him alive on Feb 17 1948

Immediate cause of death

DURATION

Due to Uremic Poisoning
Hypertrophy of Prostate2 wks
6 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 110 S. Centre St Date signed 2-21-48

RECEIVED

MAR 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

01215

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

3. (a) FULL NAME

Richard G. Dolly

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

July 24, 1943

8. AGE:

4

Years

Months

6

Days

14

If less than one day

hrs.

min.

9. Birthplace

Maryland (Cumberland)

(Town, county, and state)

10. Usual occupation

Child

11. Industry or business

Woodrow Dolly

12. Name

West Virginia

13. Birthplace

14. Maiden name

Eleanor Myers

15. Birthplace

West Virginia

16. Informant

Address

Memorial Hospital

17.

Burial & Removal

Date thereof

2/10/48

(Burial, cremation, or removal, Which?)

(month) (day) (year)

Cemetery or crematory

Green Hill Ceme.

Location

Charles Town, West Va.

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Md.

19.

Feb. 10

19

48Winter R. Grant

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Route 4 Mexico Farms
 (If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

February 8, 1948, at 6:55 P. M.

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-7- 19 48, to 2-8- 19 48and that I last saw him alive on 2-8- 19 48Immediate cause of death Diphtheria

DURATION

5 days

Due to

Due to

Other conditions Larynx - trachea -bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations

Laryngeal stenosis

Date of op.

Autopsy results

Membrane extended front all trachea

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Lester E. Daugherty

M. D. or other

Address

7 Wash St Cumberland Md

Date signed

2-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU Y. S.

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01216

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
134 Bedford St.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 134 Bedford St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mrs Agnes Glover Duckworth

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife James E. Duckworth
 7. Birth date of deceased (mo., day, yr.) Feb 16, 1882
 6. (c) If alive, give age 70 years
 8. AGE: Years 65 Months 11 Days 24 If less than one day
 hrs. min.

9. Birthplace Lonsconing, Allegheny Co. Md.
 (Town, county, and state)

10. Usual occupation Seamstress

11. Industry or business Lazarus

12. Name Thomas Holmes

13. Birthplace Ireland

14. Maiden name Susan McFarlane

15. Birthplace Ireland

16. Informant James E. Duckworth

Address 134 Bedford St - Cumberland Md

17. Burial Date thereof Feb 12, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonsconing Md.

18. Funeral director John J. Gbler

Address Cumberland Md.

19. Feb 12, 1948 Walter R. Dwyer, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 16 19 48 at MD

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 to Feb 10 19 48

and that I last saw her alive on Feb 10 19 48

Immediate cause of death Cerebral Hemorrhage

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Kester M. D. or other

Address 134 Bedford St Date signed 2/12/48

RECEIVED

FEB 18 1948

WHEAT V. S.

RECEIVED
JUN 9 1942
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

01218

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Conwell
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

712 Cecilia St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Conwell
(If outside city or town limits, write RURAL and give nearest town)Street No. 712 Cecilia St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Clara Alberta Emerick

3. (b) Social Security Number

217-10-5834

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 18 1903

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

44320

hrs.

min.

9. Birthplace

Int Savage, Maryland
(Town, county, and state)

10. Usual occupation

artificial silk worker

11. Industry or business

Belarus

12. Name

John Emerick

13. Birthplace

Pa.

14. Maiden name

Clara Jane Kennell

15. Birthplace

Pa.

16. Informant

El Roy Emerick

Address

Conwell Ind

17. Burial

Conwell

Date thereof

Feb 11 48
(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Rose Hill Cem.

Location

Conwell Ind

18. Funeral director

Dono Stein Inc

Address

Conwell

19. Feb 11 1948

(Date rec'd by registrar)

19. 48

Walter Q. Bantz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8 19 48 at 1:50 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Jan 47 19 48 to Feb 8 19 48and that I last saw her alive on Feb 7 19 48

Immediate cause of death

Coronary Atherosclerosis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. M. Schumaker, M.D.

M. D. or other

Address

41 Emerick

Date signed

Feb 9, 1948

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V S

Outside of
City Limits

Yevaskis Sr.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

01219

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Narrows Park near Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs
Hospital, institution, or street address where death occurred:
RFD #6 Cumberland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State md County Allegany
City or town Narrows Park near Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.F.D. #6 Cumberland
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Rachael Elizabeth Eagle

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Wm Eagle

7. Birth date of deceased (mo., day, yr.) Nov 19, 1872 6.(c) If alive, give age _____ years

8. AGE: Years 75 Months 2 Days 22 If less than one day _____ hrs. _____ min.

9. Birthplace Paw Paw, Morgan Co. W. Va.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business at Home

12. Name Fishell

13. Birthplace W. Va

14. Maiden name Unknown

15. Birthplace 1

16. Informant Mrs Bruce Crothers

Address 34 Carpenter Ave - Ridgely W. Va

17. Burial Date thereof Feb 14, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Allegany Cem.

Location Gravelly rd.

18. Funeral director John J. Hafer

Address Cumberland md

19. Feb. 14, 1948 W.R. Nantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11, 1948 at 6:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 10 to Feb 11 1948

and that I last saw her alive on Feb 10 1948

Immediate cause of death Arterial Hemorrhage DURATION 1 day

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. St. Yevaskis, Jr. M.D. M. D. or other

Address Cumberland md Date signed 2/14/48

MARGIN RESERVED FOR BINDING

I

9745-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V. S.

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138
W 27
L 7
M 9

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

01220

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 70 Years
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY
City or town 223 FROST AVE CITY
(If outside city or town limits, write RURAL and give nearest town)
Street No. CUMBERLAND, MARYLAND
(if rural, give LOCATION)
2(a) If veteran, name war

3. (a) FULL NAME

FROST ISABELLE MRS.

3. (b) Social Security Number

None

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED
6. (b) Name of husband or wife FROST, FREDERICM
7. Birth date of deceased (mo., day, yr.) DECEMBER 25 1869
8. AGE: Years 78 Months 2 Days 1 If less than one day hrs. min.

9. Birthplace PA.
(Town, county, and state)

10. Usual occupation HWEE

11. Industry or business

12. Name LEWIS, JAMES
13. Birthplace Wales
14. Maiden name MORRIS HELEN
15. Birthplace Wales

16. Informant Mrs Bertha Goodyear

Address 704 Shades Lane, Cumberland, Md.

17. Burial Date thereof 3/1/48
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Feb. 28, 1948 W.R. Fautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 26, 1948, at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 25, 1948, to Feb. 26, 1948, and that I last saw him alive on Feb. 26, 1948.

Immediate cause of death Broncho-pneumonia DURATION 1 week

Due to

Due to

Other conditions Carcinoma Left Breast
Elephantiasis
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.R. Fautz, M.D.
Cumberland, Md. M. D. or other 2/27/48

Address Date signed

MARGIN RESERVED FOR BINDING

9.45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19. 2-6

(Date rec'd by registrar)

19. 48

mu Nancy N. Roe

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town FrostburgStreet No. 49 Linden St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 3

19

48 at 6:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 6

19

48

to

Feb 3

19

48

and that I last saw her

alive on

Feb 3

19

48

Immediate cause of death

Chc Myocarditis

DURATION

6.5 mo

Due to

HypertensionSeveral years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm C Lane

M. D. or other

Address

Frostburg Md.

Date signed

2-5-48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01222 4

1. PLACE OF DEATH:

County AlleganyCity or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7200Hospital, institution, or street address where death occurred 507 Beall St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Chamberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 507 Beall St.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Jan 20 18686. (c) If alive, give age — years8. AGE: Years 80 Months 0 Days 11 It less than one day hrs. min.9. Birthplace Ellerslie Ind.
(Town, county, and state)10. Usual occupation none

11. Industry or business

12. Name George A. Griffey Pa.13. Birthplace Pa.14. Maiden name Catherine Miller Pa.15. Birthplace Pa.16. Informant Bms. S. N. GoodrichAddress Chamberland17. Burial Date thereof Feb 3 48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill Cem.Location Chamberland18. Funeral director Louis Stein Inc.Address Chamberland19. Feb. 3 19 48 W. H. Tautz, Jr. D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1 19 48 at 1:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19 37 to Feb. 1 19 48and that I last saw him alive on Jan. 30 19 48Immediate cause of death Charles Myocarditis

DURATION

Due to HypertensionDue to Cardio-vascular-Renaldisease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. M. McLaughlin M.D.Address #9 Green St. Date signed 2/2/48

RECEIVED
FEB 10 1948
OFFICE OF THE
DIRECTOR

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

01223

4

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 Yrs 23 Days
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 638 Washington St
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Charles W. Grimes

3. (b) Social Security Number
None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Divorced
6. (b) Name of husband or wife Jeanette Price
6. (c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) January 20, 1903
8. AGE: Years 45 Months 0 Days 23 If less than one day hrs. min.

9. Birthplace Cumberland, Allegany Co., Md
(Town, county, and state)
10. Usual occupation Restaurant
11. Industry or business "

12. Name Charles W. Grimes, Sr
13. Birthplace Cumberland, Md.
14. Maiden name Agnes Hudson
15. Birthplace Cumberland, Md.

16. Informant Mrs. Agnes Grimes
Address 638 Washington St, Cumberland, Md.

17. Burial Date thereof Feb 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Hill Crest Burial Park
Location Cumberland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. Feb 14 19 48 W. H. Kight, M. D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13 19 48 at 3-15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 12 19 48 to Feb. 13 19 48
and that I last saw him alive on Feb. 12 19 48
Immediate cause of death

Due to Pneumonia DURATION 4 days
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. M. Schmitter md M. D. or other Feb 14 1948
Address 411 Everett Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161c

01224

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 monthsHow long in hospital or institution? dead on arrivalHow long in hospital or institution? dead on arrivalHow long in hospital or institution? dead on arrival

3. (a) FULL NAME

James William Hall4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced single6. (b) Name of husband or wife None7. Birth date of deceased (mo., day, yr.) Dec. 4- 19478. AGE: Years 5 Months 1 Days 28 If less than one day hrs. min.9. Birthplace Cumberland Md.
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name William Hall13. Birthplace Cumberland Md.14. Maiden name Mary Norris15. Birthplace Cumberland Md.16. Informant William HallAddress 906 Gay St. Cumberland Md.17. Burial Date thereof Feb 2 48
(Burial, cremation, or removal) Which (month) (day) (year)Cemetery or crematory St Lukes Cem.Location Cumberland Md.16. Funeral director Louis Stein, Inc.Address Cumberland19. Feb 3 48 W.R. Lantz M.D.
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 906 Gay St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2 19 48 at 12:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead Feb. 2 19 48Immediate cause of death Acute congestion of the lungs about 5 hours.Due to a cold, had a slight cough about two weeks.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Deputy Medical Examiner - Allegany Co.23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
M. D. of Allegany Co.Address Cumberland Md. Date signed 2-2-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 10 1948
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01225

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Allegheny Hospital
 How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Penna. County Bedford
 City or town Rural Hyndman
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.D. #1
 (If rural, give LOCATION)
 2.(a) If veteran, name war ☒

3. (a) FULL NAME

Max Terrall Hamilton

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) June 15, 1947
 8. AGE: Years 7 Months 16 Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Md.
 (Town, county, and state)
 10. Usual occupation Infant
 11. Industry or business _____

FATHER 12. Name Francis Hamilton
 13. Birthplace Akron, Ohio.
 MOTHER 14. Maiden name Dorothy E. Smith
 15. Birthplace Davis, W. Va.

16. Informant Mr. Francis Hamilton
 Address R. D. #1 Hyndman, Penna.
 17. Burial Date thereof Feb. 3, 1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Rose Hill Cem.
 Location Cumberland, Md.

18. Funeral director Charles L. George
 Address Cumberland, Md.

19. Feb 3 19 48 W R Traub M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 1, 19 48 at _____ M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 18 19 48 to Feb. 18 19 49
 and that I last saw him alive on Feb. 1 19 48

Immediate cause of death malnutrition DURATION 4 weeks

Due to _____

Due to _____

Other conditions severe nutritional 4 weeks
anemia Psittosis
 (Include pregnancy within 3 months of death)

Major findings of operations _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE A. M. M. M.D. M. D. or other _____Address 59 Greene St. Date signed 2-2-48

RECEIVED
FEB 10 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01226

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County Allegany
 City or town Cumberland Md
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 1 day
 Hospital, institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 17 South Waverly Terrace
 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Charlotte
Hammond

3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

widow

6.(b) Name of husband or wife

Edmond Hammond

7. Birth date of deceased (mo., day, yr.)

Oct 21, 1883

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

6443

hrs.

min.

9. Birthplace

Parkersburg, W. Va.
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

San Prospect

12. Name

W. Va.

13. Birthplace

unk

14. Maiden name

unk

15. Birthplace

unk

16. Informant

Greenleaf Funeral Home

Address

Parkersburg, W. Va.

17.

(Burial, cremation, or removal. Which?)

burial

Date thereof

Feb 27, 1948

(month) (day) (year)

Cemetery or crematory

Parkersburg Cemetery

Location

Parkersburg, West. Va.

18. Funeral director

Louis Stein, Inc.

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

Feb 24, 1948W. H. Trautz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1948 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 17 1948 to Feb 24 1948and that I last saw her alive on Feb 24 1948

Immediate cause of death

Cardiac Paralysis

DURATION

1 day

Due to

Paralysis agitans

DURATION

8 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. H. Trautz, M.D.

M. D. or other

Address Cumberland, Md. Date signed 2-24-48

RECEIVED

MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01227

1. PLACE OF DEATH:

County Westernport AlleganyCity or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs

Hospital, institution, or street address where death occurred:

216 Vine St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ma. County AlleganyCity or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Vine

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Betty Dell Harrison

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Joseph Harrison6. (c) If alive, give age 80 years7. Birth date of deceased (mo., day, yr.) April 1, 18748. AGE: Years 73 Months 10 Days 6 If less than one day9. Birthplace Swanquarter-Hyde-N. Corlinia

(Town, county, and state)

10. Usual occupation House-wife11. Industry or business Own-Home12. Name John H.C. Berry13. Birthplace N.C.14. Maiden name Polly Anna Harris15. Birthplace N.C.16. Informant Joseph HarrisonAddress Westernport, Md.17. Removal Feb. 9, 48

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Swanquarter, N.C.Location Swanquarter, N.C.18. Funeral director Ellsworth, S. BoalAddress Westernport, Md.19. Feb. 8 19 48 Paul R. Wilson, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 7, 1948 19 48 at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

NOV. 2 19 47 to Feb 7 19 48and that I last saw her alive on Feb 6 19 48

Immediate cause of death

Cancer of Right Kidneywith MetastasisDURATION 6 Months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Paul R. Wilson, M.D.Address Piedmont, W. Va. Date signed 2-8-48

194



Outside of
City Limits

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH

468

01228

Reg. Dist. No. 7

1. PLACE OF DEATH:
County Allegheny
City or town near Cumberland - Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, institution, or street address where death occurred:
Rt. 3, Bowman's Addn
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt. 3, Bowman's Addn
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella Hast
3. (b) Social Security Number None

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Albert Hast
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) November 18, 1876
8. AGE: Years 71 Months 3 Days 7 If less than one day
hrs. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
12. Name Adam Treuschleim
13. Birthplace Unknown
14. Maiden name Matrina Jammer
15. Birthplace Germany

16. Informant J. Louis Hast
Address Rt. 3, Cumberland, Md.
17. Burial Date thereof February 27, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory Hillcrest Cemetery
Location Cumberland, Md.
18. Funeral director John J. Hoff
Address Cumberland, Md.
19. Feb 27 19 48 W.R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25 19 48 at 4:10 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 19 48 to Feb 25 19 48
and that I last saw her alive on Feb 23 19 48

Immediate cause of death Cancer of liver
DURATION 1 year
Due to
Due to
Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE R.H. Treviski, M.D.
Address Cumberland, Md. Date signed 2/26/48

RECEIVED

MAR 2 1948

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

830

01229

4

CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 yrs.
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 12 N. Lee St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mr Mark Patrick Healy 3. (b) Social Security Number 705-09-9777

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Catherine Brady
7. Birth date of deceased (mo., day, yr.) March 12, 1883
6.(c) If alive, give age years

8. AGE: Years 64 Months 11 Days 10 It less than one day hrs. min.

9. Birthplace Vale Summit, Allegany Co., Md.

10. Usual occupation machinist Healey

11. Industry or business B & O. Railroad

12. Name John Healy

13. Birthplace Scotland

14. Maiden name Margaret Mallon

15. Birthplace Golden Shaft, Md.

16. Informant Michael J. Healy
Address 416 N. 7th St. Altogether 9th

17. Burial Date thereof Feb 25, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St. Michael's Cemetery

Location Frostburg, Md.

18. Funeral director John J. Haffer
Address Cumberland Md

19. Feb 24, 1948 W.R. Frank, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 22, 1948 at 5:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15, 1948, to Feb 22, 1948
and that I last saw him alive on Feb 21, 1948

Immediate cause of death Cerebral Hemorrhage DURATION 4 days

Due to Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results. PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE B. M. Shindler M. D. or other
Address 416 N. Lee St Date signed Feb 23, 1948

RECEIVED

MAR 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01230

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town New Cumberland, West
(If outside city or town limits, write RURAL and give nearest town)Street No. Bedford Road (If rural, give location) P. O. #3

2. (a) If veteran, name war

3. (a) FULL NAME

Adelaide Hite

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife William Hite7. Birth date of deceased (mo., day, yr.) 1863 Unknown

8. AGE: Years Months Days If less than one day

85??hrs. min.9. Birthplace Concord, Penna.

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name David Goshorn13. Birthplace Penna.14. Maiden name Margaret Lacy15. Birthplace Penna.16. Informant Mrs. W. O. WolfordAddress R.D.#3 Cumberland, Md.17. Burial Date thereof Feb. 24, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. HebronLocation Winchester, Va.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Feb. 23, 1948 W. R. Frank, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec Feb 20, 1948 at 5:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I Dec 46 Feb 20 1948and that I last saw her Feb. 16 1948Immediate cause of death Myocardial FailureDURATION 5 minDue to Myocardial Degeneration 2 yrsDue to Saunility 10 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D.Address 110 S. Centre St Date signed 2-21-48

RECEIVED

MAR 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

01231

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yearsHospital, institution, or street address where death occurred:
MEMORIAL HOSPITALHow long in hospital or institution? 7 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town Near CUMBERLAND, Rural
(If outside city or town limits, write RURAL and give nearest town)Street No. RT # 3 BEDFORD ROAD
(If rural, give LOCATION)

2. (a) If veteran, name war _____

3. (a) FULL NAME

HOFFMAN, ETHEL MAE MRS

3. (b) Social Security Number

None4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced MARRIED6. (b) Name of husband or wife LOUIS E. HOFFMAN7. Birth date of deceased (mo., day, yr.) MARCH 11, 1890 6. (c) If alive, give age 59 years8. AGE: Years 57 Months 11 Days 8 If less than one day _____ hrs. _____ min.9. Birthplace WEST VIRGINIA
(Town, county, and state)10. Usual occupation HOUSEWIFE

11. Industry or business _____

12. Name JOHNSON SCOTT BARRETT13. Birthplace PENNSYLVANIA14. Maiden name JANE SPONSER15. Birthplace PENNSYLVANIA16. Informant MEMORIAL HOSPITAL
CUMBERLAND, MARYLAND
Address _____17. Burial Date thereof Feb. 22, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Everett CemeteryLocation Everett, Pa.18. Funeral director John J. HofusAddress Cumberland, Md.19. Feb. 21 19 48 Winter Pleasant
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 19, 19 48 at 10:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to Feb. 19 19 48
and that I last saw him alive on July 19 19 48Immediate cause of death myocardial infarction DURATION _____Due to hypertension after _____heart attack _____Due to following appendectomy _____

Due to _____

Other conditions Congestive heart failure _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

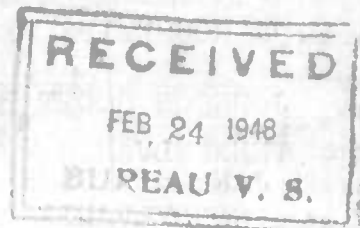
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Dr. Septer M. D. or other _____Address per Bedford St Date signed 2/20/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01232

1. PLACE OF DEATH:

County Allegany
City or town Rural Old Town
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

R.D.#1

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Rural Old Town
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D.#1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Laura Virginia Hughes

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 28, 1860

8. AGE: Years 87 Months 11 Days 18 If less than one day _____ hrs. _____ min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name Joseph Hughes13. Birthplace Maryland14. Maiden name Caroline Yantz15. Birthplace Maryland16. Informant Mr. Millard HughesAddress R.D.#1 Old Town, Md.

17. Burial Date thereof Feb. 18, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.

19. Feb. 18, 1948 Mrs C.A. Shankholtz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 16, 1948 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 15, 1948 to Feb 16, 1948
and that I last saw him alive on Feb 15, 1948

Immediate cause of death

Cardiac FailureSenility

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE MRS. GEORGE W.D.

733 V a ave M. D. or other 2/17/48
Address Date signed

RECEIVED

FEB 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01233

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegheny
 City or town Frederick
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 5 hrs.
 Hospital, institution, or street address where death occurred:
250 Center St.,
 How long in hospital or institution? 2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State 2nd County Allegheny
 City or town Birds
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. P.O. Box 1 Frederick Md
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Bessie Agnes Ryde

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife William J. Ryde
 7. Birth date of deceased (mo., day, yr.) Feb. 26th, 1895 6.(c) If alive, give age 59 years
 8. AGE: Years 52 Months 0 Days 0 If less than one day hrs. min.

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 26 1948 at 10:55 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1, 1948, to Feb. 26 1948
 and that I last saw him alive on Feb. 26 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

30 min.

Due to

Hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Gattens M.D. M. D. or otherAddress Frederick, Md Date signed 2/27/48

9. Birthplace Garrett County, Md
 (Town, county, and state)
 10. Usual occupation Housewife
 11. Industry or business
 12. Name Mary Shivers
 13. Birthplace Unknown
 14. Maiden name Mary Fitzgerald
 15. Birthplace Unknown
 16. Informant Mr. Wm. J. Ryde
 Address P.O. Box 1 Frederick Md
 17. Burial Date thereof 2-29-1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Catholic Hill
 Location Frederick, Md
 18. Funeral director James J. Ryde
 Address Frederick Md
 19. 2-29 1948 Mrs. Nancy A. Roe
 (Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 3 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

01234

CERTIFICATE OF DEATH

Reg. Dist. No. 304

1. PLACE OF DEATH:

County Allegany
 City or town Little Orleans
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 43 years
 Hospital, institution, or street address where death occurred: _____
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)
 State Md. County Allegany
 City or town Little Orleans
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Christina Imes

3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Ellis Imes
 7. Birth date of deceased (mo., day, yr.) January 28, 1905 6. (c) If alive, give age 52 years
 8. AGE: Years 43 Months 0 Days 14 it less than one day _____ hrs. _____ min.

9. Birthplace Little Orleans, Allegany Co., Md.
 (Town, county, and state)

10. Usual occupation House wife

11. Industry or business Cooking home

12. Name Henry J. McDonald

13. Birthplace Allegany Co., Md.

14. Maiden name Sarahannah Chingzman

15. Birthplace Bedford Co., Pa.

16. Informant Ellis Imes

Address Little Orleans, Md.

17. Burial Date thereof Feb. 14, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Little Orleans, Md.

18. Funeral director Charles R. Bast

Address Hancock, Md.

19. 2/14/48 19 _____
 (Date rec'd by registrar) Registrar John Heller

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11, 1948 at 7:05 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10, 1948 to Feb. 11, 1948

and that I last saw her alive on Jan. 10, 1948

Immediate cause of death Carcinoma of breast & hip DURATION about 4 mos.

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE J. A. Watson M. D. or other _____

Address Little Orleans, Md. Date signed 2/11/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1948

BUREAU V. S.

DR. DURRETT

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

132

01235

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

4 DAYS

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution?

4 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town KITZMILLER
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

216-01-4909

3. (a) FULL NAME

AUSTIN EARL KELLER

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

SINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

DECEMBER 16, 1899

8. AGE:

Years

Months

Days

If less than one day

48

2

9

hrs.

min.

9. Birthplace

Elk Garden, West Virginia
(Town, county, and state)

10. Usual occupation

Coal Mines

11. Industry or business

Coal Mine

FATHER

12. Name

RICHARD KELLER

13. Birthplace

W. VA.

MOTHER

14. Maiden name

REBECCA JANE STEMPLE

15. Birthplace

W. VA.

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 28, 1948

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Feb. 26, 1948 W. R. Tantz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 25, 1948 at 1:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 17, 1948, to Feb. 25, 1948

and that I last saw him alive on Feb. 25, 1948

Immediate cause of death

Uraemia

DURATION

6 weeks

Due to

Hypertension

18 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clayton L. Lunn

M. D. or other

Address Cumberland Date signed 2/25/48

MARGIN RESERVED FOR BINDING

VS A15 9.45.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH: Garett, Allegany
 County.....
 City or town..... Accident
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 days
 Hospital, institution, or street address where death occurred:
Miners' Hospital
 How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State..... Md County..... Garett
 City or town..... Accident
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....
 (If rural, give LOCATION)
 2.(a) If veteran, name war..... ☒

3. (a) FULL NAME
Christena Keller

3. (b) Social Security Number
None

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced
Married

6. (b) Name of husband or wife Luther Keller
 7. Birth date of deceased (mo., day, yr.) May II- 1890
 6. (c) If alive, give age 58 years

8. AGE: Years 57 Months 9 Days 15 If less than one day
 hrs. min.

9. Birthplace R.D.I Accident Md
 (Town, county, and state)

10. Usual occupation House Work

11. Industry or business

12. Name Christain Beitzell
 13. Birthplace Germany

14. Maiden name Susan Bowman
 15. Birthplace R.D.I Accident Md

16. Informant Luther Keller
 Address Accident Md

17. Burial 2-29-1948
 (Burial, cremation, or removal, Which?) (month) (day) (year)
 Cemetery or crematory Accident Cemetery
 Location Accident Md

18. Funeral director Wm Winterberg
 Address Grantsville Md

19. 2-27 44 Mr. Nancy K. Re
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26 19 48 at 9:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
November 19 47, to February 26 19 48
 and that I last saw him alive on 2/26 19 48

Immediate cause of death Pulmonary embolus

DURATION
15 min

Due to Postoperative Thrombus??

Due to
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations hemothorax, cystic
& resected Date of op. 2/19/48

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Hilda Jankowski M.D.
 Address Frostburg Md Date signed 2/26/48

RECEIVED

MAR 1 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Paul R. "also" 93d 01237

Reg. Dist. No. 6

1. PLACE OF DEATH: **Allegany**
 County **Westernport - rural**
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **50 years**
 Hospital, institution, or street address where death occurred:
1 mile north of westernport
 How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State **Maryland** County **Allegany**
 City or town **Westernport - rural**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **1 mile north westernport**
 (If rural, give LOCATION)
 2.(a) If veteran, name war - - - - -

3. (a) FULL NAME **PROCTOR WILSON KITSMILLER**

3. (b) Social Security Number

4. Sex **Male** 5. Color or race **white** 6. (a) Single, married, widowed, or divorced **Married**
 6. (b) Name of husband or wife **Edna E. Kitzmiller**
 6. (c) If alive, give age **62** years
 7. Birth date of deceased (mo., day, yr.) **February 1, 1872**
 8. AGE: Years **76** Months **0** Days **22** If less than one day
 hrs. min.

9. Birthplace **Shaw, Mineral, W. Va.**
 (Town, county, and state)
 10. Usual occupation **Miner**
 11. Industry or business **Coal Mine**
 12. Name **John Henry Kitsmiller**
 13. Birthplace **not known**
 14. Maiden name **Margaret Thrush**
 15. Birthplace **not known**

16. Informant **Mr. Burton Grove**
 Address **Westernport, Maryland**
 17. **Burial** Date thereof **Feb 26, 1948**
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory **Philos Cemetery**
 Location **Westernport, Md**
Ellsworth S. Boal
 18. Funeral director **Westernport, Maryland**
 Address

19. **Feb. 26** 19 **48** **W. Va.**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **February 23** 19 **48** at **9:30p.** M

21. I CERTIFY that death occurred on the date above stated; that I **found** deceased from **Feb 22** 19 **48** to **Feb 23** 19 **48**
 and that I last saw him alive on **Feb 23** 19 **48**

Immediate cause of death **Coronary Thrombosis** DURATION **1 Day**

Due to **chronic Hypertension and Myocardial Degeneration Not Specified AS Rheumatic** 2 Years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations **None**

Date of op.

Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: **None**
 Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Paul R. Wilom M.D.** M. D. or other

Address **Piedmont, W. Va.** Date signed **2-26-48**

RECEIVED

FEB 28 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01238

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Allegheny Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegheny
City or town Rural near Clarysville
(If outside city or town limits, write RURAL and give nearest town)Street No. Rt. 1, Cumberland Md.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Albert William Klavuhn, Jr.

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

MEDICAL CERTIFICATION

2D. DATE OF DEATH February 22, 1948 at 7:00 P.M.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
February 19, 1948 to Feb. 22, 1948
and that I last saw him alive on February 19, 1948

Immediate cause of death

terminal pneumonia

DURATION

4 daysDue to upper respiratory infectionDue to /

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Tracheotomy
Heart removalDate of op. 2-22-48

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

W. R. Frantz, M.D.

M. D. or other

Address 59 Green St. Date signed 2-24-48

11. Industry or business

12. Name Albert W. Klavuhn, Sr.13. Birthplace Pittsburgh, Pa.14. Maiden name Ruth W. Klavuhn15. Birthplace Cumberland, Md.16. Informant Albert W. Klavuhn, Sr.Address Rt. 1, Cumberland, Md.17. Burial Date thereof Feb. 25, 1948

(Burial, cremation, or removal. Which?) (month) (day) (year)

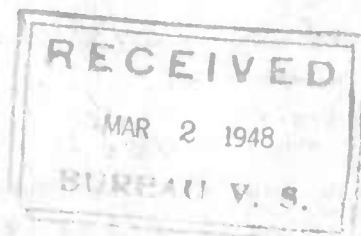
Cemetery or crematory Trinity Lutheran CemeteryLocation Cumberland, Md.18. Funeral director John J. HarperAddress Cumberland, Md.19. Feb. 24, 1948 W. R. Frantz, M.D.

(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Evidence for the change of
age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

02381

Form No. G 11 FEB 20 1948 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County... Allegheny
City or town... Frederick
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Spencer Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State... Maryland County... Allegheny
City or town... Frederick
(If outside city or town limits, write RURAL and give nearest town)
Street No... P.O. Box 362
(If rural, give LOCATION)
2.(a) If veteran, name war...

3. (a) FULL NAME

Michael Larin

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
6. (b) Name of husband or wife Rose Anna Folk
7. Birth date of deceased (mo., day, yr.) Apr. 2 - 1874
8. AGE: Years 74 Months 4 Days 7 If less than one day hrs. min.

9. Birthplace... Allegheny, Md.
(Town, county, and state)

10. Usual occupation... Retired Mother

11. Industry or business... Coal Mines

12. Name... John Larin

13. Birthplace... Spain

14. Maiden name... Ellen Baxter

15. Birthplace... Frederick, Md.

16. Informant... Miss Edith Larin

Address... Box 362 P.O. No. 1 Frederick

17. Burial, cremation, or removal, Which? Burial Date thereof 2-12-48
(month) (day) (year)

Cemetery or crematory... St. Michael's Cem.

Location... Frederick, Md.

18. Funeral director... Jacob W. W. W.

Address... Frederick, Md.

19. 2-11-48 48 Miss Nancy K. Rose
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... February 9 19 48 at 11:00 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 7 19 48 to February 9 19 48

and that I last saw him alive on February 9 19 48

Immediate cause of death Broncho Pneumonia

Due to... Bronchial Asthma + myocarditis

Due to...

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE W. E. Gattens M.D.

Address... Frederick, Md. Date signed 2/10/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Handwritten notes and signatures, mostly illegible.

RECEIVED
FEB 14 1948
RECEIVED

Handwritten notes and signatures at the bottom left, mostly illegible.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 012389

1. PLACE OF DEATH:

County Allegany
City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/2 yrs.
Hospital, institution, or street address where death occurred:
St. Mary's Hospital
How long in hospital or institution? 20 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. _____
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Thomas Francis Lee

3. (b) Social Security Number

218-07-1415

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife _____

7. Birth date of deceased (mo., day, yr.) July 11th 1871 6. (c) If alive, give age _____ years

8. AGE Years 76 yrs. Months 7 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation Retired Coal Miner

11. Industry or business _____

12. Name Tom Lee

13. Birthplace Ireland

14. Maiden name Mary Barry

15. Birthplace Ireland

16. Informant Mary Lee

Address 44 Maple St. Frostburg, Md.

17. Burial Date thereof Feb. 25th 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Michael's Cem.

Location Frostburg, Md.

18. Funeral director Daugherty Bros.

Address Frostburg, Md.

19. 2-25 19 48 Mrs. Nancy H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 23, 48 at 2:30 P.
19 48 M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 16, 1948 to February 23, 1948.
and that I last saw him alive on February 23, 1948.

Immediate cause of death Acute myocarditis DURATION 1 week

Due to Atherosclerosis

Due to Chronic Bronchitis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

_____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

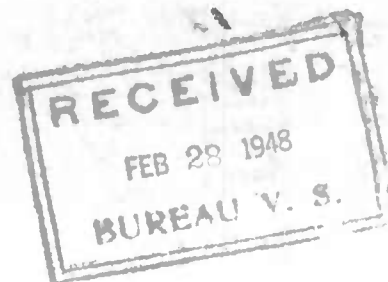
23. SIGNATURE H.C. Diehl, M.D.
M. D. or other _____

Address Frostburg, Md. Date signed 2/24/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01240

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58 years
Hospital, institution, or street address where death occurred
164 Ormsford St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)
State Ind. County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 164 Ormsford St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Ida Isabelle Mann Lech

3. (b) Social Security Number

none

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Russell C. Lech
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) Feb. 4 1875

8. AGE: Years 72 Months 73 Days 11 It less than one day 29 hrs. min.

9. Birthplace Little Orleans, Ind.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Leah B. Mann

13. Birthplace Little Orleans, Ind.

14. Maiden name Mary Esau

15. Birthplace Little Orleans, Ind.

16. Informant Mrs. Lee Kourson

Address 164 Ormsford St. Frostburg

17. Burial, cremation, or removal, Which? Burial Date thereof Feb. 6 - 1948
(month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Ind.

18. Funeral director Calvin Bailey

Address Frostburg, Ind.

19. 2-6 48 Mrs. Nancy X. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 19 48 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19 42 to Feb 3 19 48
and that I last saw him alive on 1/16 19 48

Immediate cause of death Coronary Occlusion

Due to Heart disease (coronary)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Jansler M.D. or other

Address Frostburg, Ind. Date signed 2/5/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Outside of
City Limits

Wisconsin

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

47c

01241

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs
Hospital, institution, or street address where death occurred:
at 2 Willowbrook Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Allegheny
City or town near Cumberland Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rt 2 Willowbrook Rd
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Charles Leon

3. (b) Social Security Number

216-18-1175

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
6.(b) Name of husband or wife Margaret Dicks
6.(c) If alive, give age 39 years
7. Birth date of deceased (mo., day, yr.) Jan 17, 1897
8. AGE: Years 51 Months 1 Days 18 If less than one day
hrs. min.

9. Birthplace Italy (Town, county, and state)
10. Usual occupation Construction Worker
11. Industry or business Odd Jobs
12. Name Salvino Leon
13. Birthplace Italy
14. Maiden name Maria Cardinella
15. Birthplace Italy

16. Informant Mrs Eliza Leon
Address Rt 2 Cumberland Ind
17. Burial Date thereof Feb 9 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)
Cemetery or crematory St Patricks Cemetery
Location Cumberland Ind
18. Funeral director John J. Zifer
Address Cumberland Ind
19. Feb 9 19 48 Wm R Bantz, MD
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 19 48 at 9:10 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb Nov 19 47, to Feb 5 19 48
and that I last saw him alive on Feb 5 19 48

Immediate cause of death Carcinoma
(Bronchogenic) Right Lung
DURATION 2 yrs

Due to
Due to
Other conditions

(Include pregnancy within 3 months of death)
Major findings of operations Inoperable Carcinoma
Date of op. 1946, 1947
Autopsy results no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE Levitt G. Weisenman MD
22 Feb 48 Cumberland M. D. or other
Address Date signed 2/9/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, no correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01242

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Brookharp
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 hours
 Hospital, institution, or street address where death occurred:
Miners' Hospital
 How long in hospital or institution? 6 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Gilmore
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Ellis G. Lewellyn

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Child

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

May 29, 1939

8. AGE:

Years 8 Months 8 Days 20 If less than one day _____ hrs. _____ min.

9. Birthplace

Lonaconing, Md.
 (Town, county, and state)

10. Usual occupation

None

11. Industry or business

FATHER

12. Name Ellis G. Lewellyn

13. Birthplace Gilmore, Md.

MOTHER

14. Maiden name Evelyn Beaman

15. Birthplace Bethesda, Md.

16. Informant Mr. Ellis G. Lewellyn

Address Gilmore, Md.

17. Burial Date thereof Oct. 21, 1948

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Brookharp, Md.

18. Funeral director M. Eichhorn

Address Lonaconing, Md.

19. 2-21 1948 Mr. Nancy H. Roe

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1948 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/18 to 2/19 and that I last saw him alive on 2/18

Immediate cause of death

Bilateral Pneumonia

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. _____

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul Eugene Dye, M.D.

Address Lonaconing, Md. Date signed 2/20/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01242

1. PLACE OF DEATH:

County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 weeks

Hospital, institution, or street address where death occurred:

Allegany Hospital
How long in hospital or institution? 4 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Midland
(If outside city or town limits, write RURAL and give nearest town)Street No. ---
(If rural, give LOCATION)2. (a) If veteran, name war ---

3. (a) FULL NAME

Violet Bertha Loar

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife ---

7. Birth date of

deceased (mo., day, yr.)

April 6th 19316. (c) If alive, give age --- years

8. AGE:

Years

Months

Days

If less than one day

16105--- hrs.--- min.

9. Birthplace

Midland, Allegany, Md.
(Town, county, and state)

10. Usual occupation

School Girl

11. Industry or business

Beall High School

MOTHER

FATHER

12. Name

Thomas Loar

13. Birthplace

Vale Summit, Md.

14. Maiden name

Arnellia Llewellyn

15. Birthplace

Gilmore, Md.

16. Informant

Mrs. Noah Loar

Address

Midland, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 15, 1948
(month) (day) (year)

Cemetery or crematory

Allegany Cemetery

Location

Frostburg, Md.

18. Funeral director

M. Eichhorn

Address

Lonaconing, Md.

19. Feb. 13

1948

Date rec'd by registrar

W. Alfred van Dine

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 11,

19

48

at

10:30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 29,

19

48

to

Feb. 11,

19

48

and that I last saw her alive on

Feb. 11, 1948

Immediate cause of death

Acute myelogenous leukemia

DURATION

6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Alfred van Dine

M. D. or other

Address 110 S. Centre St. Cumberland, Md.

Date signed

Feb. 13, 1948

RECEIVED

FEB 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Rural Keyser W. Va.
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. #3.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Helen Martz

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 5, 1932

6.(c) If alive, give age years

8. AGE: Years Months Days If less than one day
15 11 7 hrs. min.9. Birthplace Cresaptown, Md.
(Town, county, and state)10. Usual occupation Student

11. Industry or business

12. Name Frank Martz13. Birthplace Maryland14. Maiden name Mary Casserly15. Birthplace Maryland16. Informant Mr. Frank MartzAddress R.D. #3 Keyser, W. Va.17. Burial Date thereof Feb. 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. Ambrose Cem.Location Cresaptown, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Feb. 14, 1948 W.R. Tautz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 12, 1948 at 3:40 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 17, 1948 to Feb. 12, 1948
and that I last saw him alive on Feb. 12, 1948Immediate cause of death Heart Oplastic Anomoly DURATION 6 wks

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Same

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.R. Tautz M.D. or otherAddress Cumberland, Md. Date signed 2/14/48

RECEIVED

FEB 18 1943

BUREAU V. S.

DR. SCHINDLER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01245

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County... ALLEGANYCity or town... CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

MEMORIAL HospitalHow long in hospital or institution? 6 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County AlleganyCity or town... CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 529 PINE ST.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

FRANCIS H. MCCOY

4. Sex

MALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

MARRIED6. (b) Name of husband or wife SUSAN MCCOY7. Birth date of deceased (mo., day, yr.) NOV. 19, 19026. (c) If alive, give age 39 years

8. AGE:

Years

Months

Days

If less than one day

45220

hrs.

min.

9. Birthplace... MARYLAND (Cumberland)
(Town, county, and state)10. Usual occupation... Employee of B&ORR11. Industry or business B & O RR12. Name... GRANT MCCOY13. Birthplace WA14. Maiden name... EMMA LYNCH15. Birthplace PA16. Informant... Susan Walters Mc CoyAddress Cumberland, Md.17. Burial Date thereof 2/12/1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Davis Memorial Ceme.Location Uhl Highway Cumberland, Md18. Funeral director... Louis Stein Inc.Address Cumberland, Md19. Feb 11 19 48 Walter R Grant Registrar
(Date rec'd by registrar)

3. (b) Social Security Number

217-10-4163

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 9, 19 48 at 1:20 P

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

January 1 19 48 to Feb. 9 19 48
and that I last saw him alive on Feb. 9 19 48

Immediate cause of death

DURATION

Brown Tumor Frontal lobe (Urbach)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

B. M. Schindler M. D. of the Feb 17/1948
Address 41 Greenleaf Date signed

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

01246

1. PLACE OF DEATH:

County *Allegheny*City or town *Cumberland*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? *40 yrs*

Hospital, institution, or street address where death occurred:

36 Somerville Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Allegheny*City or town *Cumberland*
(If outside city or town limits, write RURAL and give nearest town)Street No. *36 Somerville Ave*
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Effie Rebecca Meyers

3. (b) Social Security Number

*None*4. Sex *Female*5. Color or race *White*6. (a) Single, married, widowed, or divorced *Widowed*6. (b) Name of husband or wife *Geo H Meyers*

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *Sept 18 1878*8. AGE: Years *69* Months *5* Days *3* If less than one day hrs. min.9. Birthplace *Enochs Pa.*
(Town, county, and state)10. Usual occupation *Housewife*11. Industry or business *at home*12. Name *Jacob Joseph Burkhardt*13. Birthplace *Perma.*14. Maiden name *Elizabeth Fleckinger*15. Birthplace *Perma.*16. Informant *Jas. Meyers*Address *Cumberland*17. *Burial* Date thereof *7-23-48*
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory *Trinity Lutheran Cem.*Location *Cumberland Ind.*18. Funeral director *Louis Stein Jas.*Address *Cumberland*19. *Feb 23, 1948 W.D. Fautz M.D.*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb 21* 19 *48* at *4:25* A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Sept.* 19 *47* to *February 21 48*and that I last saw him alive on *February 18 48*

Immediate cause of death

DURATION

Generalized Arteriosclerosis 3 yrs

Due to

Due to

Due to

Other conditions

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *J. S. Johnson M.D.*Address *Cumberland Md.* Date signed *2-23-48*

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 2 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 01247 2

1. PLACE OF DEATH:

County AlleganyCity or town Greentown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Lillie Morgan

3. (b) Social Security Number

4. Sex Female5. Color or race White6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife:

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) 11-14-19168. AGE: Years 31 Months 3 Days 11 If less than one day _____ hrs. _____ min.9. Birthplace Greentown, Allegany, Md.

(Town, county, and state)

10. Usual occupation House work11. Industry or business none12. Name D. H. Morgan13. Birthplace Greentown, Md.14. Maiden name Sara B. Jordan15. Birthplace Greentown, Md.16. Informant John ClimermanAddress 7 Flintstone Rd.17. Burial Date thereof 2/28/48

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory Greentown Rd.Location Greentown18. Funeral director Edith SmithAddress Antemas, Pa.19. Feb. 27 19 48 Miss L. Bender

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Greentown

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rural - Star Butte

(If rural, give LOCATION)

2. (a) If veteran, name war _____

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 25 19 48 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Apr 1 19 46 to Feb 25 19 48and that I last saw him alive on Feb 7 19 48

Immediate cause of death _____

DURATION

Pulmonary tuberculosis

Due to _____

complicated withDue to colitis

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE H. M. Schaffer, M.D.

M. D. or other

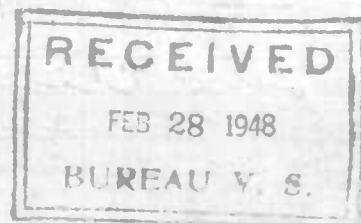
Address Hancock, Md. Date signed 2/26/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Burial Permit



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH Dr P E Berry ^{93d} 01248
2411 N. Charles St., Baltimore
CERTIFICATE OF DEATH Reg. Dist. No. 6

1. PLACE OF DEATH: Allegany
County Westernport
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 Years
Hospital, institution, or street address where death occurred:
135 Front Street
How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 135 Front Street
(If rural, give LOCATION)
2. (a) If veteran, name war - - - - -

3. (a) FULL NAME

PATRICK FRANCIS MORGAN

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Catherine A. Morgan
6. (c) If alive, give age 82 years
7. Birth date of deceased (mo., day, yr.) May 4, 1860
8. AGE: Year 87 Months 9 Days 0 If less than one day - - - - - hrs. - - - - - min.

9. Birthplace Scotland
(Town, county, and state)
10. Usual occupation Miner
11. Industry or business Coal Mine
12. Name Peter Morgan
13. Birthplace Scotland
14. Maiden name not known
15. Birthplace not known

16. Informant Mrs Patrick F. Morgan
Address Westernport, Maryland
17. Burial Date thereof Feb 6, 1948
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory St Peters Cemetery
Location Westernport, Maryland
18. Funeral director Ellsworth S. Boal
Address Westernport, Maryland

19. Feb. 6 19 48
(Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 19 48 12:30 a m
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 19 48, to Feb 19 48
and that I last saw him alive on February 1 19 48

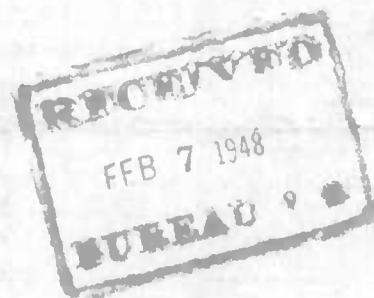
Immediate cause of death Chronic myocarditis
Due to Atherosclerosis

Other conditions - - - - -
(Include pregnancy within 8 months of death)
Major findings of operations - - - - -
Date of op. - - - - -

Autopsy results - - - - -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide - - - - - Date of - - - - -
Where did injury occur? - - - - - (City or town) - - - - - (County) - - - - - (State)
Injured at home, farm, industry, public place (where?) - - - - -
Means of injury - - - - - Injured at work? - - - - -

23. SIGNATURE P. E. Berry MD
Address Piedmont Va Date signed Feb 5/48



CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, give RURAL and give nearest town)How long in above place of death? 46 years

Hospital, institution, or street address where death occurred:

225 Emily St.How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 225 Emily St.
(If rural, give LOCATION)2. (a) If veteran, name war ✓

3. (a) FULL NAME

Frances Elizabeth Murray

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

James H. Murray6. (c) If alive, give age - years

7. Birth date of

deceased (mo., day, yr.)

January 12, 1957

8. AGE:

Years

Months

Days

If less than one day

91113

hrs.

min.

9. Birthplace

Benwood, W. Va.

(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

Queen City Hotel

MOTHER FATHER

12. Name

Joseph Murray

13. Birthplace

Benwood, W. Va.

14. Maiden name

Rose Hanson

15. Birthplace

Benwood, W. Va.

16. Informant

Maquette Burns

Address

225 Emily St.

17.

(Burial, cremation, or removal. Where?)

Date thereof

(month) (day) (year)

BurialFeb. 28, 1948

Cemetery or crematory

St. Patrick's Cemetery

Location

Cumberland, Md.

18. Funeral director

M. Eichhorn

Address

Loracoring, Md.

19.

(Date rec'd by registrar)

19. 48

W.R. Frantz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 25, 1948 at 8:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2/19/48

19.

2/25/48

19.

and that I last saw him alive on 2/25/48 19.

Immediate cause of death

Cerebral Hemorrhage

DURATION

7 days

Due to

Cerebral HemorrhageNot

Due to

Similarity

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None

Date of op.

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

None

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, pub'c place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. H. Frantz

M. D. or other

Address

140 Pauline St.Date signed 3/25/48

RECEIVED

MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01250

Reg. Dist. No. 6

1. PLACE OF DEATH:

County... Allegany
 City or town... Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 85 years
 Hospital, institution, or street address where death occurred:
329 Vine Street
 How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County... Allegany
 City or town... Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 329 Vine Street
 (If rural, give LOCATION)
 2.(a) If veteran, name war - - - - -

3.(a) FULL NAME

HENRY WILLIAM NAU

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowere
 6.(b) Name of husband or wife Mary F Nau
 7. Birth date of deceased (mo., day, yr.) September 28, 1858
 6.(c) If alive, give age - - - years
 8. AGE: Years 89 Months 4 Days 16 if less than one day
 hrs. min.

9. Birthplace Piedmont, Mineral, W. Va.
 (Town, county, and state)
 10. Usual occupation Blacksmith
 11. Industry or business Railroad
 12. Name Conrad Nau
 13. Birthplace Germany
 14. Maiden name Theresa Hoffman
 15. Birthplace Germany

16. Informant Mrs David Mongold
 Address Westernport, Maryland
 17. Burial Date thereof Feb 17, 1948
 (Burial, cremation, or removal, which?) (month) (day) (year)
 Cemetery or crematory St Peters Cemetery
 Location Westernport, Maryland
 18. Funeral director Ellsworth S. Boal
 Address Westernport, Maryland

19. Feb 17 1948
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 13, 1948 at 5:45p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 5 1947 to Feb 13 1948
 and that I last saw him alive on Feb. 13 1948

Immediate cause of death Pulmonary Edema DURATION 1 Day
 Due to Chronic Hypertension and Myocardial Degeneration Not Specified as Rheumatic 1 Year
 Other conditions Generalized Edema 5 Months

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. _____

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

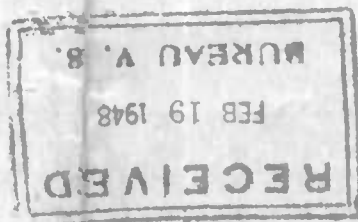
22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide None Date of _____

Where did injury occur? _____
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul R Wilson M.D.
 Address Piedmont W. Va Date signed Feb. 17, 1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01251

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town C. Sherrard
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 47 yrs.Hospital, institution, or street address where death occurred:
911 Lexington Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 911 Lexington Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Bessie Amelia Field

3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

George Wm Field

7. Birth date of deceased (mo., day, yr.)

Oct 2, 18776. (c) If alive, give age 72 years

8. AGE:

Years

Months

Days

It less than one day

70415

hrs. min.

9. Birthplace

KnobvilleMd.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Jerere Fauble

13. Birthplace

Burkettsville, Md

14. Maiden name

Amelia Mc Bride

15. Birthplace

Burkettsville, Md

16. Informant

Miss Loretta Field

Address

911 Lexington Ave - Cumberland Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Feb 20, 1948
(month) (day) (year)

Cemetery or crematory

Hillcrest Cemetery

Location

Cumberland, Md

18. Funeral director

John J. Hager

Address

Cumberland, Md

19. Date rec'd by registrar

Feb. 20, 1948W.R. Krantz, M.D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 19 48 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 42 19 48
and that I last saw him alive on 2/17/48 19 48

Immediate cause of death

Stramien

DURATION

7 days

Due to

Atherosclerosis7 yrs

Due to

Arteriosclerosis15 yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clay S. Jones
Cumberland M.D. or other
Address Date signed 2/20/48

RECEIVED

FEB 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

107

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Eastland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 yearsHospital, institution, or street address where death occurred:
Sydney RetreatHow long in hospital or institution? 3 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State M.D. County AlleganyCity or town Frederick
(If outside city or town limits, write RURAL and give nearest town)Street No. London St.
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Margaret Parker

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife John Parker7. Birth date of deceased (mo., day, yr.) Mar. 11 - 1861

6. (c) If alive, give age _____ years

8. AGE: Years 86 Months 8 Days 23 If less than one day _____ hrs. _____ min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation Wife

11. Industry or business _____

12. Name Jacob Miller13. Birthplace Unknown14. Maiden name Elizabeth Shultz15. Birthplace Unknown16. Informant John E. ParkerAddress Wright's Crossing17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 2-7-1948
(month) (day) (year)Cemetery or crematory AlleganyLocation Frederick, Md.18. Funeral director Jacob MillerAddress Frederick, Md.19. Feb 5 19 48 W.R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Feb 3 19 48 at 11:30 P.M.21. I CERTIFY that death occurred on the date above stated; that Dec 19 46 to Feb 3 19 48and that I last saw her alive on Feb 3 19 48

Immediate cause of death _____

DURATION

Broncho pneumonia 2 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Arthur F. Jones, Jr.
M. D. or otherAddress 110 S. Centre St. Date signed 2-4-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01253

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County AlleghenyCity or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? Life time

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleghenyCity or town Eckhart
(If outside city or town limits, write RURAL and give nearest town)Street No.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Catherine Isabel Phillips

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Thomas Phillips7. Birth date of deceased (mo., day, yr.) July 5, 1868 6. (c) If alive, give age years8. AGE: Years 79 Months 5 Days 22 If less than one day hrs. min.9. Birthplace Eckhart, Allegheny, Md. (Town, county, and state)10. Usual occupation Dancer, job

11. Industry or business

12. Name Andrew Nelson13. Birthplace Ireland14. Maiden name Jane Lester15. Birthplace Eckhart, Md.16. Informant Miss Anna PhillipsAddress Eckhart, Md. 1348317. Burial, cremation, or removal, which? Burial Date thereof Apr. 1-1948 (month) (day) (year)Cemetery or crematory AlleghenyLocation Frostburg18. Funeral director James W. WafferAddress Frostburg, Md.19. 3-1 19 48 Mr. Harvey R. Roe Registrar2D. DATE OF DEATH February 27, 1948 at 8:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 27, 1948 to February 27, 1948and that I last saw him alive on February 24, 1948Immediate cause of death General InanitionDue to Intestinal flu and colitis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Jansel Walther M.D.Address Frostburg Md. Date signed 2/28/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 3 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

01254

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

122 South St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 122 South St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

John Albert Reed

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Emma Hogamier

7. Birth date of deceased (mo., day, yr.) July 18, 1902
 6.(c) If alive, give age 44 years

8. AGE: Years 45 Months 6 Days 25 If less than one day
hrs.min.

9. Birthplace Cumberland, Allegany Co., Md.
(Town, county, and state)10. Usual occupation Maintenance Foreman11. Industry or business Bata Shoe Factory12. Name John W. Reed13. Birthplace Maryland14. Maiden name Sophia Eschenbacher15. Birthplace Maryland16. Informant Mrs. Emma ReedAddress 122 South St. Cumberland, Md.17. Burial Date thereof Feb. 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory S.S. Peter & Paul Cem.Location Cumberland, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.19. Feb. 14, 1948 W.R. Frank, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 13, 1948 at 11:16 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/16 to Feb. 13, 1948and that I last saw him alive on 2/13 19 48

Immediate cause of death

Sudden heart failure (myocardial infarction)Due to myocardial disease 2 yr.Due to ischemic heart disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.R. Frank, M.D. M. D. or otherAddress La Vale, Md. Date signed 2/14/48

RECEIVED

FEB 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01255

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 86-5-4

Hospital, institution, or street address where death occurred:

302 Arch St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 302 Arch St.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Mary E. Reichart

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Joseph J. Reichart

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

September 15, 1861

8. AGE:

86

Months 5

Days 4

It less than one day

hrs. min.

9. Birthplace

Cumberland, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

FATHER

12. Name

Mary

13. Birthplace

unk.

MOTHER

14. Maiden name

unk.

15. Birthplace

unk.

16. Informant

Peter C. Reichart

Address

302 Arch St. Cumberland Md.

17.

(Burial, cremation, or removal, which?)

Date thereof

Feb. 23, 1948
(month) (day) (year)

Cemetery or crematory

St. Peter's & Paul's Cemetery

Location

Cumberland Md.

18. Funeral director

Louis Stern, Inc.

Address

Cumberland Md.

19.

Feb. 21, 1948

19

W. H. Trout, M. D.

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 19, 1948 11:40 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

3 p.m. 1947 to Feb. 19, 1948
and that I last saw him alive on Nov. 1948

Immediate cause of death

Cerebral Hemorrhage

DURATION

Due to

Atherosclerosis 15 yrs.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Clay J. [Signature]
Cumberland Md. 2/19/48

Address

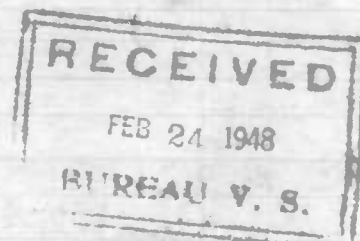
Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01256

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
South Water St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. South Water St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

DAISY KNEPP RICHARDSON

3. (b) Social Security Number

213-10-9720

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Charles Richardson

7. Birth date of deceased (mo., day, yr.)

December 27, 1912

6. (c) If alive, give age 38 years

8. AGE:

Years
35Months
1Days
27If less than one day
hrs. min.9. Birthplace Frostburg (rural) Garrett, Md.
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

home

MOTHER
FATHER

12. Name

Phillip Knepp,

13. Birthplace

Garrett County, Md.

14. Maiden name

Bertha Blocher,

15. Birthplace

Frostburg, Md.

16. Informant

Charles Richardson,

Address

Frostburg, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof Feb. 26, 1948
(month) (day) (year)

Cemetery or crematory

Allegany Cemetery,

Location

Frostburg, Md.

18. Funeral director

J. R. Durst,

Address

Frostburg, Md.

19.

2-26

(Date rec'd by registrar)

19

48 Mr. Nancy N. Rae
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24, 1948 at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 6, 1942 to Feb 24, 1948and that I last saw him alive on February 23, 1948

Immediate cause of death

Uremia

DURATION

4 days

Due to

Cardiovascular renal disease5 years

Due to

Rheumatic heart disease15 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

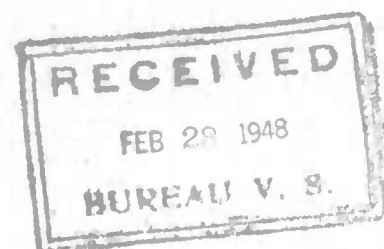
Injured at work?

23. SIGNATURE

Hilda J. Gwaltney, M.D.

M. D. or other

Address Frostburg, Md. Date signed 2/24/48



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

01257

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 Years

Hospital, institution, or street address where death occurred:

1101 Lafayette Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 1101 Lafayette Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Myrtle Cecelia Riley

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife James C. Riley

7. Birth date of deceased (mo., day, yr.)

June 13, 18796. (c) If alive, give age 73 years

8. AGE:

Years

Months

Days

If less than one day

6885

hrs.

min.

9. Birthplace Martinsburg, W. Va.

(Town, county, and state)

10. Usual occupation Housewife11. Industry or business Own home12. Name Jeremiah Ambrose13. Birthplace Great Cacapon, W. Va.14. Maiden name Phoebe Tobler15. Birthplace North Mountain, W. Va.16. Informant James C. RileyAddress 1101 Lafayette Ave. Cumberland, Md.17. Burial
(Burial, cremation, or removal, Which?)Date thereof February 20, 1948
(month)(day)(year)Cemetery or crematory Hillcrest CemeteryLocation Cumberland, Md.18. Funeral director John J. HooperAddress Cumberland, Md.19. Feb. 20, 48
(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 18 1948, at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 1978, to Feb. 18 1948
and that I last saw her alive on Feb. 10 1948

Immediate cause of death

Cerebral Thrombosis

DURATION

2 hrsDue to Atherosclerosis10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

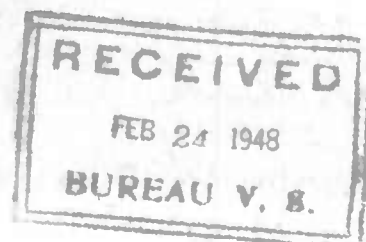
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. R. Frank M.D.
Address 136 Fourth Cumberland, Md. Date signed 2/18/48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH Dr Reeves

2411 N. Charles St., Baltimore 93d

01258

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH: Allegheny
 County.....
 City or town.....Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 28 years
 Hospital, institution, or street address where death occurred:
306 Walnut Street
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State.....Maryland County.....Allegheny
 City or town.....Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.....306 Walnut St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
DAVID COLOMBUS RITCHIE

3. (b) Social Security Number
216-09-6424

4. Sex.....Male 5. Color or race.....White 6. (a) Single, married, widowed, or divorced.....Married
 6. (b) Name of husband or wife.....Bessie G. Ritchie
 7. Birth date of deceased (mo., day, yr.).....November 10, 1880
 8. AGE: Years.....67 Months.....3 Days.....2 If less than one day.....hrs.min.

9. Birthplace.....Berghon, Rockingham, Virginia
 (Town, county, and state)
 10. Usual occupation.....Beaterman helper
 11. Industry or business.....W. V. a. Pulp and Paper Co
 12. Name.....George Ritchie
 13. Birthplace.....Virginia
 14. Maiden name.....Elizabeth Souter
 15. Birthplace.....Virginia

16. Informant.....Miss Edith Ritchie
 Address.....Westernport, Md.

17. Burial.....Feb 15, 1948
 (Burial, cremation, or removal, Which?).....Philos Cemetery
 Cemetery or crematory.....Westernport, Md.
 Location.....Ellsworth S. Boal

18. Funeral director.....Westernport, Maryland
 Address.....

19. Feb. 15 19 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION
 20. DATE OF DEATH.....February 12 19 48 at 10:55a M

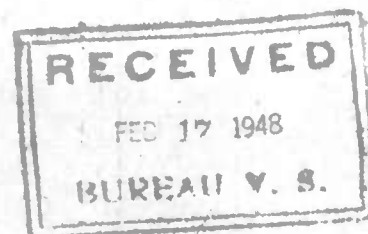
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11 19 48 to Feb 12 19 48 and that I last saw him alive on 2/12/48

Immediate cause of death.....Chronic Myocarditis
Coronary artery disease
 Due to.....
 Due to.....
 Other conditions.....

(Include pregnancy within 3 months of death)
 Major findings of operations.....
 Date of op.....
 Autopsy results.....
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide..... Date of.....
 Where did injury occur?..... (City or town)..... (County)..... (State).....
 Injured at home, farm, industry, public place (where?).....
 Means of injury..... Injured at work?.....

23. SIGNATURE.....Dr. Reeves M. D. or other.....
 Address.....Westernport Md Date signed 2/14/48



Within corporate limits.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The present age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46d

01259

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4-0 yrs
 Hospital institution, or street address where death occurred:
Memorial Hospital
 How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 115 Bedford St.
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Lewis Rosenbaum

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed
 6. (b) Name of husband or wife Rose Price
 7. Birth date of deceased (mo., day, yr.) Nov. 18 1859
 6. (c) If alive, give age years
 8. AGE: Years 88 Months 2 Days 25 If less than one day
hrs. min.

9. Birthplace Neembressen Germany
 (Town, county, and state)
 10. Usual occupation Retired Purchaser
 11. Industry or business Dept. Store
 12. Name Isaac Rosenbaum
 13. Birthplace Germany
 14. Maiden name Regina
 15. Birthplace Germany

16. Informant Mrs Sylvia Schuch
Cumberland
 Address
 17. Burial Date thereof Feb 15 48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory East View Cem.
Cumberland
 Location
 18. Funeral director Louis Stein Inc
Cumberland Ind.
 Address
 19. Feb 14 48 W. H. Nantz, M.D.
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 19 48 at 3:39 P.
 21. I CERTIFY that death occurred on the date above stated: that I attended deceased from
Jan 21 19 48 to Feb 13 19 48
 and that I last saw him alive on Feb 13 19 48
 Immediate cause of death Cirrhosis of Liver
Carcinoma of the Rectum
metastases to
mesentery
 Other conditions Paralytic ileus and severe
osteomyelitis of vertebrae
 (Include pregnancy within 3 months of death)
 Major findings of operations
 Date of op.
 Autopsy results negative
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE Samuel J. Rosenberg
50 Pershing St M. D. or other
 Address Date signed 2/14/48

RECEIVED

FEB 18 1948

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164a

01260

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County... Allegany
City or town... Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 Years
Hospital, institution, or street address where death occurred:
1711 Bedford St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Md. County... Allegany
City or town... Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1711 Bedford St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME

Louis Edward Ruby

3.(b) Social Security Number

220-10-1543

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Leona Fultz Ruby

7. Birth date of deceased (mo., day, yr.) Sept. 23- 1883 6.(c) If alive, give age 53 years

8. AGE: Years 64 Months 4 Days 19 If less than one day hrs. min.

9. Birthplace Beans Cove Pa. Bedford Co
(Town, county, and state)

10. Usual occupation laborer-B&O. R.Ry

11. Industry or business

12. Name Lewis Ruby

13. Birthplace Beans Cove, Pa.

14. Maiden name Nancy Rose

15. Birthplace Centerville, Pa.

16. Informant Mrs Leona Ruby

Address 1711 Bedford St, Cumberland, Md.

17. Burial Date thereof Feb 16, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Seven Dolors Catholic Cemetery

Location Beans Cove, Pa.

18. Funeral director William H. Kight

Address Cumberland, Md.

19. Feb. 14 19 48 W.R. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

about

20. DATE OF DEATH Feb. 12 19 48 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him Dead Feb. 12 19 48

Immediate cause of death Strangulation by hanging. DURATION about 10 min.

Due to despondency

Other conditions Chronic myocarditis about 3 years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 2-12-48

Where did injury occur? Cumberland Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury hung himself in cellar Injured at work? no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

Address Cumberland Md. Date signed 2-12-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 18 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01261

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 7 Years

Hospital, institution, or street address where death occurred:

511 Maryland Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 511 Maryland Ave.
(If rural, give LOCATION)2. (a) If veteran, name war None

3. (a) FULL NAME

Clinton Carlton Shade4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Altafay Kalbaugh7. Birth date of deceased (mo., day, yr.) October 17, 18888. AGE: Years 59 Months 4 Days 6 It less than one day hrs. min.9. Birthplace Winchester, Frederick Co., Va.
(Town, county, and state)10. Usual occupation Retired Merchant11. Industry or business Grocery Store12. Name Charles F. Shade13. Birthplace Frederick Co., Va.14. Maiden name Elizabeth Jane Clark15. Birthplace Frederick Co., Va.18. Informant Raymond R. ShadeAddress 411 Broadway, Cumberland, Md.17. Burial Date thereof Feb. 26, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Philos IOOF CemeteryLocation Westernport, Maryland18. Funeral director John J. HaferAddress Cumberland, Md.19. Feb. 26 19 48 W. L. Frank, M.D.
(Date rec'd by registrar) Registrar

3. (b) Social Security Number

215-20-5411

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23 19 48 at 3.15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48 to 19 48and that I last saw him alive Dead Feb. 23 19 48Immediate cause of death Coronary occlusion at once

DURATION

Due to Diabetes mellitus several years.Other conditions Diabetes mellitus several years.

(Include pregnancy within 3 months of death)

Major findings of operations Coronary occlusion at onceDate of op. Feb. 23, 1948Autopsy results Diabetes mellitus several years.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Diabetes mellitus several years.Where did injury occur? Diabetes mellitus several years.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Diabetes mellitus several years.Means of injury Diabetes mellitus several years.Injured at work? Diabetes mellitus several years.Signature H. V. Deming M.D. H. V. Deming M.D.Address Cumberland Md. Date signed 2-23-48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1142-05-21

RECEIVED

MAR 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 8

01262

1. PLACE OF DEATH:

County Allegany
 City or town Barton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 58 years
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Allegany
 City or town Barton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

James Peter Shaw

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Johanna E. Leruth7. Birth date of deceased (mo., day, yr.) Feb 16, 1860 8.(c) If alive, give age _____ years8. AGE: Years 88 Months 0 Days 7 It less than one day _____ hrs. _____ min.9. Birthplace Maryland (Town, county, and state)10. Usual occupation Farming11. Industry or business Own farm12. Name John Shaw13. Birthplace Unknown14. Maiden name Nancy Michael15. Birthplace Trim Rock, Md.16. Informant Mrs. David MillerAddress Barton, Md.17. Burial Date thereof Feb 26, 1948

(Burial, cremation, or removal, Which?) month (day) (year)

Cemetery or crematory Laurel Hill CemeteryLocation Indecor, Md.18. Funeral director M. EichhornAddress Indecor, Md.19. Feb 26 19 48 Janette M. Boal
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 23 19 48 at 9:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 22 19 48 to Feb. 23 19 48and that I last saw him alive on Feb. 23 19 48Immediate cause of death Pulmonary Edema and DURATION 2 DaysUremia 1 YearDue to Chronic NephritisandDue to Chronic Myocarditis and MyocardialDegeneration Not specified as rheumatic 1 Year

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. _____Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

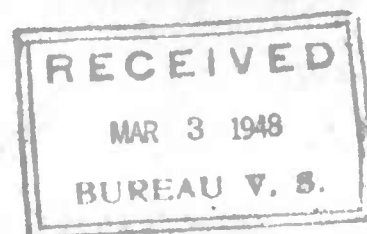
Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Paul R. Wilson, M.D. M. D. or other _____Address Piedmont, W. Va. Date signed Feb. 25, 1948



RECEIVED

MAR 3 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits *Dr. Fred Williams*

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01263

Reg. Dist. No. *4*

1. PLACE OF DEATH:

County *Allegheny*City or town *Cumberland*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

540 Rose Hill Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Allegheny*City or town *Cumberland*

(If outside city or town limits, write RURAL and give nearest town)

Street No. *540 Rose Hill Ave.*

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

James Causten Shriver

3.(b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

*Male**White**Married*6.(b) Name of husband or wife *Gertrude E. Weible*7. Birth date of deceased (mo., day, yr.) *Nov. 14, 1870*6.(c) If alive, give age *60* years

8. AGE: Years Months Days If less than one day

*77**2**20**hrs.**min.*9. Birthplace *Cumberland, Md.*

(Town, county, and state)

10. Usual occupation *Retired*11. Industry or business *U.S. Postmaster*12. Name *Henry Shriver*13. Birthplace *Maryland*14. Maiden name *Sarah VanLear Perry*15. Birthplace *Maryland*16. Informant *Mrs. Gertrude Shriver*Address *540 Rose Hill Ave. Cumberland Md*17. *Cremation* Date thereof *Feb. 5, 1948*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory *Homewood Crematorium*Location *Pittsburgh, Penna.*18. Funeral director *Charles L. George*Address *Cumberland, Md.*19. *Feb 5, 1948* *W. F. Trautz, M.D.*

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *Feb. 4, 1948* at *6:55 P.M.*21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Jan. 31, 1948* to *Feb. 4, 1948*and that I last saw him alive on *Feb. 1, 1948*

Immediate cause of death

DURATION

Largintoma of Cecum

Due to

Due to

Other conditions

(Include pregnancy within 2 months of death)

Major findings of operations *Those of above*Date of operation *July 22-47*Autopsy results *None*

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Wm. F. Williams*Address *Cumberland* Date signed *2/4/48*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County... *Allegany*City or town... *Mt Savage*
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

John Simpson

3. (b) Social Security Number

215-10-1314

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Amelia M Simpson

7. Birth date of deceased (mo., day, yr.)

Sept 2 - 1893

6. (c) If alive, give age

50 years

8. AGE:

Years

Months

Days

It less than one day

*54**5**6*

hrs.

min.

9. Birthplace

England
(Town, county and state)

10. Usual occupation

*Kelly Springfield
Tipe plant*

11. Industry or business

FATHER
MOTHER

12. Name

Thomas Simpson

13. Birthplace

England

14. Maiden name

Susanna Johnson

15. Birthplace

England

16. Informant

Mrs Amelia M Simpson

Address

Mt Savage

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... *Feb 10 - 1948*
(month) (day) (year)

Cemetery or crematory

St. George

Location

Mt Savage Md.

18. Funeral director

Address

Frederick Md.

19. Feb 10 1948

(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md

County

Allegany

City or town

Mt Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.

Dutch Hollow
(If rural, give LOCATION)

2. (a) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH

*Feb 8*19. *48*, at *6:00 AM*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2 years 46 19. *48*, 10. *Feb 8* 19. *48*and that I last saw him alive on *Feb 7* 19. *48*

Immediate cause of death

Congestive lungs

DURATION

3 days

Due to

*Silicosis**5 years*

Due to

*Wholesale of stone
not in chest*

Other conditions

*Enlarged heart**2 years*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Allegany Md

M. D. or other

Address

*Allegany Md*Date signed *Feb 9 48*

RECEIVED

FEB 13 1948

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Dr Paul R. Wilson

Reg. Dist. No. 6

1. PLACE OF DEATH: **Allegany**
 County **Westernport**
 City or town (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **23 Years**
 Hospital, institution, or street address where death occurred:
McKinley Street
 How long in hospital or institution? - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State **Maryland** County **Allegany**
 City or town **Westernport**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. **McKinley Street**
 (If rural, give LOCATION)
 2.(a) If veteran, name war - - - - -

3. (a) FULL NAME
HERBERT LEE SLAYTON

3. (b) Social Security Number

220-10-2685

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Divorced**
 6. (b) Name of husband or wife - - - - -
 7. Birth date of deceased (mo., day, yr.) **June 23, 1904** 6. (c) If alive, give age - - - - - years
 8. AGE: Years **43** Months **8** Days **1** It less than, one day - - - - - hrs. - - - - - min.

9. Birthplace **Horton, Randolph, W. Va.**
 (Town, county, and state)
 10. Usual occupation **Bleach Plant Operator**
 11. Industry or business **W. Va. Pulp and Paper Co.**

12. Name **Franklin B. Slayton**
 13. Birthplace **West Virginia**
 14. Maiden name **Flora Montoney**
 15. Birthplace **West Virginia**

16. Informant **Mrs Flora M. Slayton**
 Address **Westernport, Maryland**
 17. **Burial** Date thereof **Feb 27, 1948**
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory **Philos Cemetery**
 Location **Westernport, Maryland**
 18. Funeral director **Ellsworth S. Boal**
 Address **Westernport, Maryland**

19. **Feb. 26** 19 **48** **Paul R. Wilson MD**
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **February 24** 19 **48** at **8:15p** M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **Mar 10** 19 **47** to **Feb 24** 19 **48**
 and that I last saw him alive on **Feb. 24** 19 **48**

Immediate cause of death
Cancer of Right Kidney

DURATION

1 Year

Due to - - - - -
 Due to - - - - -
 Other conditions - - - - -

(Include pregnancy within 3 months of death)

Major findings of operations **Cancer of Right Kidney**
 Autopsy results **None** Date of op. **Oct. 15, 1949**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: **None**
 Accident, suicide, or homicide Date of - - - - -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE **Paul R. Wilson MD.** M. D. or other

Address **Piedmont, W. Va.** Date signed **3-26-48**

RECEIVED

FEB 28 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

01266

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

Allegany Co. InfirmaryHow long in hospital or institution? 1 year

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Marie Anna Smith

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Divorced

6. (b) Name of husband or wife

Henry Smith

6. (c) ft alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

April 17 1880

8. AGE:

Years

Months

Days

If less than one day

67924

hrs.

min.

8. Birthplace

Baltimore Md.
(Town, county, and state)

10. Usual occupation

Housework

11. Industry or business

FATHER

12. Name

Henry Beller

13. Birthplace

Md.

MOTHER

14. Maiden name

Christina Daughton

15. Birthplace

Md.

16. Informant

Jos B. Daughton

Address

Willingburg Pa.

17.

Burial

Date thereof

Feb 14 '48
(month) (day) (year)

Cemetery or crematory

Willingburg Cem.

Location

Cumberland Md.

18. Funeral director

Louis Stein Inc

Address

Cumberland

19.

Feb. 14 1948
(Date rec'd by registrar)W.R. Faunt, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

February 1119. 48at 10 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 9 '46

to

Feb 1119. 48and that I last saw her alive on Feb. 10 19. 48

Immediate cause of death

Cerebral Vascular Accident
Cerebral Arteriosclerosis

Due to

DURATION

14 days
3 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Arthur F. Jones M.D.

M. D. or other

Address 1105. Centre StDate signed 2-12-48

RECEIVED

FEB 18 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01267

93d

Reg. Dist. No. 1

1. PLACE OF DEATH:

County Allegany
City or town Rural Little Orleans
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Green Ridge Station

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Rural Little Orleans
(If outside city or town limits, write RURAL and give nearest town)

Street No. Green Ridge Station
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

David S. Snyder

3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Harriet Twigg Snyder6.(c) If alive, give age 55 years7. Birth date of deceased (mo., day, yr.) Jan. 1, 1887

8. AGE: Years 61 Months 1 Days 23 If less than one day
.....hrs.min.

9. Birthplace Mill Stone Point, Md.
(Town, county, and state)10. Usual occupation Retired Trackman11. Industry or business W. Md. R.R. Co.12. Name Joseph B. Snyder13. Birthplace Maryland14. Maiden name Katherine Cardy15. Birthplace Maryland16. Informant Mrs. Harriet SnyderAddress Little Orleans, Md.

17. Burial Date thereof Feb. 26, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Robey Cem.Location Green Ridge, Md.18. Funeral director Charles L. GeorgeAddress Cumberland, Md.

19. Feb. 25, 1948 Mrs. P. A. Shankholz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 23, 1948 at 7:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1947 to February 1948
and that I last saw him alive on February 1948

Immediate cause of death Stroke, arteriosclerosis DURATION 15 yrs.

Due to

Due to

Other conditions Myocarditis 10 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. J. Johnson M. D. or otherAddress Cumberland, Md. Date signed Feb. 24, 1948

RECEIVED

FEB 28 1948

BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01268

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany
City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs
Hospital, institution, or street address where death occurred:
46 Humbird St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 46 Humbird St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Alicia Ewing Stonebraker

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
Robert E Stonebraker
B.(b) Name of husband or wife
6.(c) If alive, give age 78 years
7. Birth date of deceased (mo., day, yr.) June 1, 1863
8. AGE: Years 84 Months 8 Days 14 If less than one day
hrs. min.

9. Birthplace Verdin, Ill
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

12. Name Obadiah Ewing
13. Birthplace Ohio

14. Maiden name Narcissa Ewing
15. Birthplace St. Charles, Mo.

18. Informant Helen E. Stonebraker
Address 46 Humbird St.

17. Burial Date thereof Feb. 17, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Zion Memorial Park
Cumberland, Md.

Location Cumberland, Md.

18. Funeral director John E. Weyerh
Address Cumberland, Md.

19. Feb. 17, 1948 W.R. Fantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 15 19 48 at 11:50 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 19 46 to Feb 15 19 48
and that I last saw him alive on Feb. 14 19 48

Immediate cause of death Cerebral Vascular Accident DURATION 7 wks

Due to Cerebral Arteriosclerosis 5 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other

Address 110 S. Centre St Date signed 2-16-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 24 1948

BUREAU V. S.

Within corporate limits Evidence for
changes & additional
information is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

796

01269

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Memorial Hospital Cumberland Md.

How long in hospital or institution? 4 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 Queen City Pavement
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Earnest Clyde Summer

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 14- 1902

8. AGE: Years Months Days It less than one day
45 8 16# hrs. min.

9. Birthplace Unknown Russell Co., Va.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

12. Name Robert C. Summers

13. Birthplace Hagerstown, Md.

14. Maiden name Lou Hackett

15. Birthplace Russell Co. Va.

16. Informant Louis Stein, Mrs. Hubert Summers

Address Cumberland, Md. Appalachia, Va.

17. Burial, cremation, or removal, Which? Date thereof Feb. 23, 1948

Cemetery or crematory Summers Appalachia Cem

Location Appalachia Virginia

18. Funeral director Louis Stein, Jr.

Address Cumberland Md.

19. Feb 19 19 48 Hunter R. Bantz, M.D. Registrar

3.(b) Social Security Number

227-28-6333

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18 19 48 at 9:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Feb. 18 19 48

Immediate cause of death Cerebral hemorrhage

Due to chronic bronchial asthma

Due to

Other conditions Pantopon addict

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Medical Examiner - Allegany Co.

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.

Address Cumberland Md. Date signed 2-18-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 24 1948
BUREAU V. S.

Letter from Mr. Frank Williams, And, no time
in Operation V-2

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01270

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 35 years
 Hospital, institution, or street address where death occurred:
520 Beall St
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegheny
 City or town Cumberland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 520 Beall St
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

Mary Ellen Summers

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife J. Oscar Summers
 6. (c) If alive, give age 78 years
 7. Birth date of deceased (mo., day, yr.) January 5 1878
 8. AGE: Years 70 Months 1 Days 12 If less than one day _____ hrs. _____ min.

9. Birthplace Keyser, Mineral Co, West Virginia
 (Town, county, and state)
 10. Usual occupation House
 11. Industry or business

MOTHER FATHER
 12. Name John Noonan
 13. Birthplace Ireland
 14. Maiden name Ellen Yost
 15. Birthplace Little Cacapon, W. Va.

16. Informant Mrs. Elsie Young
 Address 520 Beall St, Cumberland, Md.

17. Burial Date thereof 2/20/48
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory St Peter & Paul Cemetery
 Location Cumberland, Md.

18. Funeral director William H. Kight
 Address Cumberland, Md.

19. Feb 19 19 48 Winter R. Hantz
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 17 19 48 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
February 10 19 48, to 2-17- 19 48
 and that I last saw h. er alive on 2-15- 19 48

Immediate cause of death acute coronary occlusion
 DURATION 5 min

Due to

Due to

Other conditions upper respiratory infection
 (Include pregnancy within 3 months of death) 1 week

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. H. King M. D. or otherAddress 59 Greene St. Date signed 2-17-48

RECEIVED

FEB 24 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01271

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Md. AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

215 Rice St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County AlleganyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 215 Rice St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Clersey Ellen Wagner

3.(b) Social Security Number

None

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widowed

6.(b) Name of husband or wife

Mr. H. Wagner

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Dec. 9, 1868

8. AGE:

Years

79

Months

2

Days

8

If less than one day

hrs.

min.

9. Birthplace

Romney, West Va.
(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

MOTHER FATHER

12. Name

William Haines

13. Birthplace

England

14. Maiden name

Catherine Holt

15. Birthplace

West. Va.

16. Informant

Leater Wagner

Address

215 Rice St, Cumberland, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 20, 1948
(month) (day) (year)

Cemetery or crematory

Cheney Cemetery

Location

Romney, West Va.

16. Funeral director

David Stein, Inc.

Address

Cumberland, Md.

19.

(Date rec'd by registrar)

Feb. 19, 1948
Walter R. Trantz, Md.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb. 17, 1948 at 4:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb. 11, 1948 to Feb. 17, 1948and that I last saw her alive onFeb. 17, 1948

Immediate cause of death

Myocarditis

DURATION

5 yrs

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

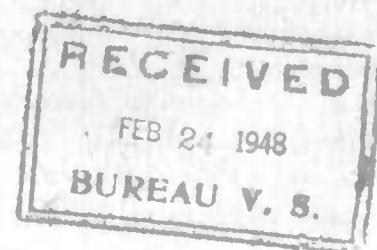
23. SIGNATURE

Clay J. Furrer
Cumberland

M. D. or other

Address Date signed 2/16/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany
 City or town Frostburg, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Rd. Grahamstown, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany
 City or town Frostburg, Grahamstown
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 51 Wright
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Louisa Wagner

3. (b) Social Security Number

none

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Geo. Wagner

7. Birth date of deceased (mo., day, yr.)

Oct. 13 - 1867

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

80

3

22

hrs.

min.

9. Birthplace

Bridgeton, Alleg.-md.

(Town, county, and state)

10. Usual occupation

housewife

11. Industry or business

David Roberts

12. Name

Walter

13. Birthplace

many, Shomaker

14. Maiden name

Walter

15. Birthplace

Wm. Wagner

16. Informant

Mr. Wm. Wagner

Address

Frostburg, Md.

17. Burial

Funeral

(Burial, cremation, or removal. Which?)

Date thereof

Feb. 8 - 1948

(Month) (day) (year)

Cemetery or crematory

Allegany

Location

Frostburg, Md.

18. Funeral director

J. R. Roberts

Address

Frostburg

19. 2-6

48 Mrs. Nancy Re

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 1948 at 2:00 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 23 1948 to Feb 5 1948

and that I last saw her alive on Feb 5 1948

Immediate cause of death

Chronic myocarditis

DURATION

6 mo

Due to

Senility

Due to

Senility

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm. C. Lane M. D. or other

Frostburg Md Date signed 2-6-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01273

Reg. Dist. No. 4

1. PLACE OF DEATH: **Allegany**
County.....
City or town..... **Cumberland**
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?.....
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?..... **7 Days**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... **Maryland** County..... **Allegany**
City or town..... **Cumberland**
(If outside city or town limits, write RURAL and give nearest town)
Street No..... **Bowman's Addition**
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME
GEORGE W. WALKER, JR.

3. (b) Social Security Number

None

4. Sex **Male** 5. Color or race **White** 6.(a) Single, married, widowed, or divorced **Single**
6.(b) Name of husband or wife..... **X**
6.(c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) **Sept 30, 1947**
8. AGE: Years Months Days It less than one day
4 27hrs.min.

9. Birthplace **Cumberland Allegany Md.**
(Town, county, and state)
At Home

10. Usual occupation.....

11. Industry or business.....

FATHER 12. Name..... **George W. Walker**

13. Birthplace..... **Moorefield, W.Va.**

MOTHER 14. Maiden name..... **Edith Shingleton.**

15. Birthplace..... **Romney, W.Va.**

16. Informant..... **Mrs G.W.Walker.**

Address..... **Cumberland, Md.**

Burial **Feb 29 1948**

17. (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)

Cemetery or crematory..... **Ebenezer Cemetery**

Location..... **Romney, W.Va.**

18. Funeral director..... **A. C. Ruckman**

Address..... **Romney, W.Va.**

19. **Feb 28 48** **Winters P. Hunt, M.D.**

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **February 27 19 48** at **1:05 A.M.**

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **February 2, 48** to **Feb. 27 19 48** and that I last saw him alive on **2/26 19 48**

Immediate cause of death..... **Laryngeal edema** DURATION **2 days**

Due to..... **respiratory infection**

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... **Elizabeth Brown M.D.**

Address..... **La Vale Md.** Date signed..... **3/4 48**

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
MAR 9 1948
BUREAU V. 8.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01274

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 Years
 Hospital, institution, or street address where death occurred:
142 MAIN ST
 How long in hospital or institution? _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany
 City or town Westernport
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 142 Main St
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3. (a) FULL NAME

Owen William Walsh

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower
 6.(b) Name of husband or wife Fannie Walsh
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) November 11, 1878
 8. AGE: Years 69 Months 2 Days 26 If less than one day _____ hrs. _____ min.
 9. Birthplace Oakland-Garrett, Maryland
 (Town, county, and state)
 10. Usual occupation Conductor (Retired)
 11. Industry or business Rail Road
 12. Name Mathias Walsh
 13. Birthplace Ireland
 14. Maiden name SABINA THORNTON
 15. Birthplace Ireland

16. Informant Mrs William Russell
 Address Westernport, Md
 17. Burial Date thereof Feb 10, 1948
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Philos Cemetery
 Location Westernport Md.
 18. Funeral director Ellsworth S. Boal
 Address Westernport Md
 19. Feb 9 19 48
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

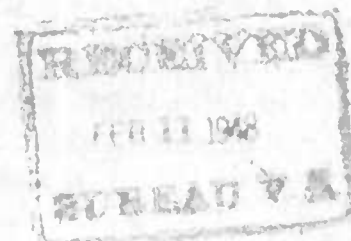
20. DATE OF DEATH February 7 19 48 at 3:00 A
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb-7 19 48 to Feb 7 19 48
 and that I last saw him alive on Wed Feb 7 19 48
 Immediate cause of death Severe myocardial infarction
 Due to Failure
 Due to _____
 Other conditions No Typhoid
 (Include pregnancy within 3 months of death)

DURATION

Major findings of operations _____ Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____
 23. SIGNATURE J. H. Keener M.D. M. D. or other _____
 Address Westernport Md Date signed Feb 9/1948



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01275

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegheny
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs.

Hospital, Institution, or street address where death occurred:

446 Baltimore Ave

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 446 Balt Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mr John Dunn Wear

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Naomi W. Tveraskis

7. Birth date of deceased (mo., day, yr.)

Aug 21, 18646. (c) If alive, give age 80 years

8. AGE:

Years 83 Months 5 Days 24 hrs. min.

9. Birthplace

Cornwall, England.
(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

Grocery

MOTHER

12. Name

Wm Wear

13. Birthplace

England

14. Maiden name

Mary Dunn

15. Birthplace

England

16. Informant

Grace Wear

Address

Cumberland, Md.

17. Burial

Burial Date thereof Feb 18, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Berwick Cemetery

Location

Berwick Pa.

18. Funeral director

John J. Hafey

Address

Cumberland Md.

19. Feb 17

(Date rec'd by registrar)

19. 48

Walter R. Kreutz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Feb 15 19 48 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Feb 14 19 48 to Feb 15 19 48and that I last saw him alive on Feb 15 19 48

Immediate cause of death

Cerebral hemorrhage

DURATION

2 hours

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

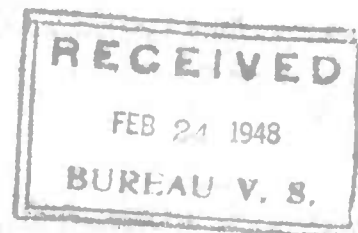
R. F. Tveraskis, Sr. M.D.
M. D. or other
Cumberland, Md. Date signed 2/16/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The format age is especially important. Physicians: please write the causes of death clearly and legibly



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01276

Reg. Dist. No. 4

1. PLACE OF DEATH

County **ALLEGANY**
 City or town **CUMBERLAND**
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? **6 DAYS**
 Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
 How long in hospital or institution? **6 DAYS**

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State **MARYLAND** County **GARRETT**
 City or town **DEER PARK, MD.**
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____ ✓

3. (a) FULL NAME

CLIFFORD WELCH

3. (b) Social Security Number

None

4. Sex **MALE** 5. Color or race **WHITE** 6. (a) Single, married, widowed, or divorced **WIDOWER**

6. (b) Name of husband or wife **HARVEY, EMILY**

7. Birth date of deceased (mo., day, yr.) **JULY 14, 1875** 6. (c) If alive, give age **72** years

8. AGE: Years **72** Months **6** Days **21** If less than one day _____ hrs. _____ min.

9. Birthplace **DEER PARK, MD. Garrett County**
 (Town, county, and state)

10. Usual occupation **RETIRED**

11. Industry or business

12. Name **Albert Welch**13. Birthplace **Ohio**14. Maiden name **Missouri Riley**15. Birthplace **Garrett County, Maryland**16. Informant **MRS. VIRGINIA LINEBAUGH**Address **FORT CUMBERLAND HOTEL**17. **Burial** Date thereof **Feb. 8, 1948**

(Burial, cremation, or removal? Which?)

Cemetery or crematory **White Church Cemetery**Location **5 mi. So. Mt. Lake Park, Md.**18. Funeral director **Herbert C. Reigle**Address **Baltimore, Md.**19. **Feb 5** 19 **48** **W. F. Williams, M.D.**

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH **FEBRUARY 5, 1948** at **3:15 A.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **1-31-1948** to **2-5-1948**and that I last saw him alive on **2-4-1948**

Immediate cause of death _____ DURATION _____

Chronic NephritisDue to **(Uremia)**

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations **None**

Date of op. _____

Autopsy results **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE **W. F. Williams**Address **Cumberland** Date signed **2/5/48**



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

01277

8

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County... Allegheny
 City or town... Quakertown
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution? L

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Allegheny
 City or town... Quakertown
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Evelyn Vlier Wilhelm

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Harry Wilhelm
 7. Birth date of deceased (mo., day, yr.) July 2, 1879 6.(c) If alive, give age 61 years
 8. AGE: Years 68 Months 7 Days 16 It less than one day hrs. min.

9. Birthplace Garrett Co., Md.
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own Home

12. Name James Vlier
 13. Birthplace Scotland
 14. Maiden name Annie M. Millam
 15. Birthplace Scotland

16. Informant Harry Wilhelm
 Address Quakertown, Md.

17. Burial (Burial, cremation, or removal (Which?) Date thereat Feb 22, 1948
 (month) (day) (year)
 Cemetery or crematory Philos Cemetery
 Location Nestonport, Md.

18. Funeral director M. Elchhorn
 Address Quakertown, Md.

19. 7/22 19 48 Janette M. Neal
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 18, 19 48 at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1 19 47 to Feb 18 19 48
 and that I last saw her alive on Feb 17 19 48

Immediate cause of death Carcinoma of
Breast
 DURATION 11 mo

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE WOM Lane MD M. D. or otherAddress Forestburg Md Date signed 2-20-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 3 1948

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01278

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 years

Hospital, institution, or street address where death occurred:

310 Washington St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County AlleghenyCity or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)Street No. 310 Washington St.

(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Bessie Alice "Echard" Willett

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married8. (b) Name of husband or wife Earl C. Willett7. Birth date of deceased (mo., day, yr.) June 3, 18876. (c) If alive, give age 51 years8. AGE: Years 60 Months 8 Days 3 If less than one day
hrs. min.9. Birthplace Mt. Lake, Garrett Co. Maryland
(Town, county, and state)10. Usual occupation Housewife11. Industry or business Own home12. Name Levi Echard13. Birthplace Pennsylvania14. Maiden name Elizabeth Hoop15. Birthplace Pennsylvania16. Informant Earl C. WillettAddress 310 Washington St., Cumberland, Md.17. Burial Date thereof February 9, 1948
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Oakland CemeteryLocation Oakland, Maryland18. Funeral director H. C. LighterAddress Oakland, Maryland19. Feb. 7, 1948 W. R. Fantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 6, 1948 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 22, 1947 to Feb. 6, 1948and that I last saw him alive on Feb. 5, 1948

Immediate cause of death

Chl. Reptentis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. R. Fantz M. D. or otherAddress 1400 E. 1st St. Date signed 2-6-48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01279

DR. T. B. HUNTER

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANYCity or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 MINUTES

Hospital, institution, or street address where death occurred:

MEMORIAL HOSPITALHow long in hospital or institution? 30 MINUTES

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLAND County ALLEGANYCity or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)Street No. 10 HARRISON ST.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

BABY BOY WILLIAMS

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MALEWHITESINGLE

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 29, 1948 01:15 P.M.8. AGE: Years Months Days If less than one day
hrs. 30 min.9. Birthplace CUMBERLAND, MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name FRANCES WILLIAMS15. Birthplace Cumberland, Md.16. Informant Memorial HospitalAddress Cumberland, Md.17. Burial Date thereof 3/3/48
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hill Crest CemeteryLocation Cumberland, Md.18. Funeral director William H. KightAddress Cumberland, Md.19. March 3, 1948 W.R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 29, 1948 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

February 28, 1948 19and that I last saw him alive on 19Immediate cause of death Premature 7 mos

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

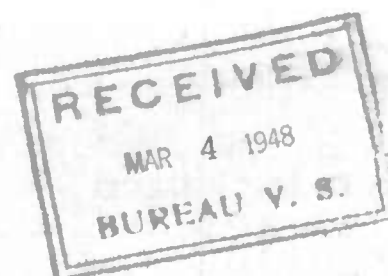
23. SIGNATURE T. Bailey Hunter MD M. D. or otherAddress Cumberland Md Date signed 3/1/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

01280

#7 2

1. PLACE OF DEATH:

County Allegany
 City or town Rural near Flintstone
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Rt 2 Cumberland Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Allegany
 City or town Rural near Flintstone
 (If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 2 Cumberland Rd.
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs Judie Perin Willison

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

widowed

6. (b) Name of husband or wife

Norval F. Willison

7. Birth date of deceased (mo., day, yr.)

July 28, 1881

6. (c) If alive, give age years

8. AGE:

Years 66 Months 6 Days 7
 If less than one day hrs. min.

9. Birthplace

Flintstone, Allegany Co, Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

Housewife

12. Name

Jerroys Perin

13. Birthplace

Flintstone Md.

14. Maiden name

Leborah Wilson

15. Birthplace

Flintstone Md.

16. Informant

Woodrow Willison

Address

Rawlings Md.

17. Burial

200 F. CemeteryFlintstone Md.

Location

18. Funeral director

John J. Hafer

Address

Cumberland Md.19. Feb 7 19 48 Nina H. Bender

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 5 19 48 at 7:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 15 19 47 to Feb 5 19 48and that I last saw him alive on Feb 19 48

Immediate cause of death

Cardiovascularrenal disease.

Due to

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work

23. SIGNATURE

John N. Rozum MD.

Address

Date signed 2/6/48

